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ABSTRACT

This manual was designed to aid undergraduate social work students working in a model field-site program for gerontological social work education. It is based on work completed on an Administration on Aging project in Texas entitled, "A Statewide Faculty Development Program for Undergraduate Social Work Educators in Elder Care." The project's primary goal was to increase the number of social workers with the knowledge and skills needed to work with older persons, especially poor, frail, or minority elders who are at risk of losing their independence. The manual is organized by topic area with information on the following learning objectives: (1) Attitudes and Facts on Aging; (2) Aging and Ethnicity; (3) Communication and Interviewing Skills; (4) Assessments, including competence in daily living, cognitive status, depression, psychosocial evaluations, and case management; (5) Health Concerns and Health Care; (6) Understanding Community Services; (7) Linking Clients to Services; (8) Financial Issues, such as funding programs for long-term care, medicare and medicaid; and (9) Legal and Ethical Issues, such as case management, the Texas Natural Death Act, and the durable power of attorney for health care. Also included are bibliographic and audiovisual guides for both students and older people and their families. (RJM)

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ED 372 308

EDUCATIONAL RESOURCE MANUAL FOR BACCALAUREATE SOCIAL WORK FIELD INSTRUCTION IN GERONTOLOGY

A Product of the Project "A Statewide Faculty Development Program for Undergraduate Social Work Educators in Eldercare"

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Texas Consortium of Geriatric Education Centers
at Baylor College of Medicine

Collaborating Institutions:
The University of Texas-Pan American Department of Social Work
The University of Texas-Austin School of Social Work
Texas Southern University Social Work Program
University of Houston Graduate School of Social Work

In Consultation with:
Texas Department on Aging

This manual was supported, in part, by grant number 90-AT-0509 from the Administration on Aging, Office of Human Development Services, Department of Health and Human Services.

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EDUCATIONAL RESOURCE MANUAL FOR BACCALAUREATE SOCIAL WORK FIELD INSTRUCTION IN GERONTOLOGY

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INTRODUCTION AND ACKNOWLEDGEMENTS

This educational resource manual is based on the work completed by the AoA Education and Training Project titled, "A Statewide Faculty Development Program for Undergraduate Social Work Educators in Elder Care". The project was sponsored by the Texas Consortium of Geriatric Education Centers located in the Huffington Center on Aging at Baylor College of Medicine. Collaborating institutions included: The University of Texas-Pan American Department of Social Work, The University of Texas-Austin School of Social Work, Texas Southern University Social Work Program and the University of Houston Graduate School of Social Work. Technical assistance and support was also provided by the Texas Department on Aging.

This manual was designed to enhance the learning experiences of undergraduate social work students working in a model field-site program for gerontological social work education. The project staff worked in conjunction with the project advisory committee listed below to develop a draft resource manual. In the Fall semester of 1992 and the Spring semester of 1993, social work field instructors and trainees affiliated with the collaborating institutions utilized and evaluated the manual.

The editors are grateful to the many people who have contributed to the development, evaluation and completion of this manual. In particular , we thank the authors of individual items in the manual. We also appreciate the ideas and contributions of the Advisory Committee members listed below, as well as the consulting staff from the University of Houston and our outstanding project consultant, Nancy R. Hooyman. Terry Saulsberry and Nancy Philips graciously spent hours typing and copying numerous drafts. Finally, we thank the social work field instructors and students who provided invaluable advice on revising and expanding the manual.

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OVERVIEW

The primary goal of our project is to increase the number of social workers that have the knowledge and skills necessary to work effectively with older persons, particularly those older people residing in the community most at risk of losing their independence. This educational resource manual was developed for the purpose of supporting the field site learning of baccalaureate social work students working with older people. The project advisory committee developed a set of student field site learning objectives and activities and the content of the manual was selected accordingly.

The objectives and potential field site learning activities are on the following pages. The manual is organized by topic area and information included is directly relevant to one or more of the learning objectives. Bibliographic material is included for student learning as well as for sharing with older people and families. Where possible, the acutal learning resource is included in the manual. However, in some instances, the reader is given a reference or phone number to contact.

Due to the dynamic nature of service delivery to a growing population, some of this information will quickly become outdated. However, we have tried to include the sources to contact for updated materials.

The ultimate goal of the project is to improve care for older Texans, especially the frail, poor, and minority elders. This project was made possible by funding from the Administration on Aging.

GERONTOLOGY TRAINING FOR BACCALAUREATE SOCIAL WORK STUDENTS:

OBJECTIVES AND ACTIVITIES FOR MODEL FIELD INSTRUCTION EXPERIENCE

Below each objective is a listing of potential activities to be considered in helping students develop the skills necessary for working effectively with older people.

1. **Develop an awareness of attitudes, biases, and values concerning work with older people and an appreciation of emphasizing cohort differences and cultural diversity in values and attitudes.**

    a. Monitor media coverage about older people and aging issues and identify attitudes reflected in coverage.

    b. Keep a "mini-journal" about interactions with older adults, the student encounters and observations of the attitudes of others.

    c. Write a brief story about a memorable older person: family, neighbor, etc.

    d. Complete an Attitudes on Aging questionnaire and discuss personal attitudes, biases, and values with site supervisor.

    e. Interview older people from different cultural backgrounds and obtain their views about societal attitudes toward aging.

    f. Interview one or more community leaders about their views of older citizens and their needs.

2. **Display effective communication and interviewing skills for work with both well and disabled older people of different racial or ethnic backgrounds and adapt these skills to different environments.**

    a. Observe field setting social workers conducting interviews for specific purposes: intake, discharge planning, counselling, etc.

    b. Role play an interview for a particular purpose .

    c. Investigate strategies for how practitioners communicate with older adults who have hearing loss, speech problems.

    d. Conduct interviews with older clients in different environments and/or for different purposes (home, hospital/intake, discharge).

3. **Develop knowledge and skills for biopsychosocial assessment in the context of problems, capacities and needs of older clients.**

   a. Review reports of assessments which evaluate the psychosocial and functional needs and capacities of older client.

   b. Observe assessment interviews in different settings and discuss differences (home vs. hospital).

   c. Conduct and write a psychosocial assessment of an older person or family.

   d. Review and practice using one or more standard assessments of an older person.

4. **Display problem-solving skills concerning common needs of older people presented within the field setting including awareness of ethical considerations in practice and differing goals of clients and others.**

   a. Generate a "problem list" based on observing an interview and discuss with the responsible practitioner.

   b. Observe intervention planning meetings within agency and "debrief" participants about the process.

   c. Participate as a member of a staffing or care planning team "debrief" participants about the process.

   d. Interview other clients about how their needs were met.

   e. Identify different viewpoints of client, family, professionals and discuss ethical aspects of different problem definitions.

5. **Develop relevant care plans to meet short and/or long-term needs of older people and their families**

   a. Develop a written care plan based on an observed interview.

   b. Write an intervention plan for a client/family and work with client through implementation documenting barriers and outcomes where possible.

   c. Review agency records of client intervention plans and discuss alternative techniques with supervisor.

   d. Interview family members and record by audiotape or notes to receive feedback.

   e. Participate as a member of care planning team.

6. **Indicate understanding of the contributions of other people to meeting the needs of older people.**

   a. Interview and/or observe professionals of other disciplines about their role in serving older people (within and outside of agency.)

   b. Review written reports of assessments or intervention efforts of another discipline.

   c. Prepare a written or verbal report on the work of a professional (other than a social worker).

7. **Develop understanding of the physical changes associated with aging, the effect of disease and individual and family adaptation to these changes.**

   a. View videotapes on chronic illness encountered in field agency.

   b. Interview clients and families regarding issues related to illness and their response to disability.

8. **Display understanding of field setting, including: its organization and mission; role in meeting the needs of one or more groups of older people; and its relationship to other service agencies.**

   a. Interview the agency or program director about the history/work of the agency.

   b. Attend/participate in a meeting of a relevant agency committee, board of directors or staff work group.

   c. Attend a meeting of other community agencies where field site is represented or involved in some way.

9. **Demonstrate ability to identify and collaborate with community resources and personnel involved in serving older clients and awareness of gaps in community services. Develop a basic knowledge of governmental policy and financing of services for older people.**

   a. Visit and learn about the services of major providers of aging services including entitlement programs such as Medicare.

   b. Prepare a written or verbal report on the services of one or more providers.

c. "Research" the local services and eligibility guidelines for one problem area such as respite care, transportation, etc.

d. Accompany an older client to another agency to help him/her apply for service.

e. Keep a log of unmet client needs or service gaps encountered as you observe practice or implement care plans.

f. Interview field instructor and other agency personnel about common service gaps.

g. Attend a local public hearing or other professional meeting concerning services for the elderly.

h. Interview a local community advocate.

10. **Become familiar with concepts of "elder care" including strategies for maximizing independence, supporting family care and utilizing community services creatively.**

a. Interview and/or observe staff of local case management programs for older people.

b. Learn about programs of corporate Elder Care and the local Area Agency on Aging through involved staff.

SOCIAL WORK WITH OLDER PEOPLE

Copies of this brochure "Social Work with Older People" can be obtained from the National Association for Social Workers, 7500 First Street - NE, Suite 700, Washington, D.C. 20002 or call 1-800-638-8799.

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ATTITUDES AND FACTS ON AGING

Glossary of Basic Terminology in Aging -- U.S. DHHS

Twentieth Century Cohorts -- N. R. Hooyman

What is Your Aging I.Q.? -- NIA

Facts on Aging: A Short Quiz -- E. Palmore

Survey of Facts and Attitudes on Aging -- N. Kogan, E. Palmore, and J. Merrill

What's on Your Mind? A Quiz on Aging and the Brain -- NIA

Profile on Aging -- AARP

Census Highlights: Sixty-Five Plus in America -- C. Taeuber, U.S. Bureau of the Census

NASW Policy on Aging -- NASW

Adapted from Age Words: A Glossary on Health and Aging by U.S. Department of Health and Human Services, 1986. NIH Publication No. 86-1849

GLOSSARY OF BASIC TERMINOLOGY IN AGING

Age segregation	The separation of people based on age --- as in retirement communities or senior citizens' centers.
Aged	The state of being old. A person may be defined as aged on the basis of having reached a specific age --- for example, 65 is often used for social or legislative policies while 75 is used for physiological evaluations.
Ageism	Prejudice against people because they are old. Ageism implies a broader meaning than gerontophobia, the unreasonable fear and hatred of older persons. The term was coined by Robert N. Butler, M.D., first Director of the National Institute on Aging.
Aging	The changes that occur normally in plants and animals as they grow older. Some age changes begin at maturity and end at death.
Centenarian	A person who is 100 years or older.
Chronological age	An individual's numerical age dating from the time of his or her birth.
Cohort	A group of people who are born at the same period of time or who enter a system, such as a nursing home, at the same time.
Dependency ratio	A comparison between those individuals whom society considers economically productive and those it considers economically unproductive. Since many people over 65 are retired from the work force, this group is usually classified as economically unproductive (other in this category are children and nonworking individuals between ages 18 and 64).
Elderly or elder	Generally referring to individuals over age 60.
Epidemiology	The study of the frequency and distribution of illness in a population.

Functional age	An assessment of age based on physical or mental performance rather than on the number of years since birth.
Geriatric medicine	Also called geriatrics. The medical knowledge of physical disability in older persons --- including the diagnosis, treatment, and prevention of disorders. Geriatric medicine recognizes aging as a normal process, not a disease state.
Geriatric psychiatry	The medical specialty concerned with mental or emotional disorders. The psychiatrist is a M.D. or a D.O. trained to diagnose and treat these disorders through a variety of methods, including psychotherapy and medications.
Geriatrician	Physicians with special training in geriatric medicine.
Gerontology	The study of aging from the broadest perspective. Gerontologists examine not only the clinical and biological aspects of aging but also psychosocial, economic, and historical conditions.
Life expectancy	A statistical projection of the number of years an individual is expected to live. Persons of the same age can have different life expectancies depending on their race, sex, or socioeconomic circumstances.
Life span	The years a human being could live if negative variables, such as disease or accidents, did not shorten the number. An ideal number, probably approaching 110 years.
Progeria	Premature aging. Progeria is a rare condition known also by the name Hutchinson-Gilford progeria syndrome. Signs begin to appear in the individual soon after birth, and the average life expectancy is approximately 12 years.
Senescence	Aging. The normal process of growing old, a process that occurs continuously at every biological level (chemical, cellular, tissue, organ systems, and organism).
Senility	An outdated term referring to abnormal deterioration in the mental functions of old people.

Source: Nancy R. Hooyman, Dean
School of Social Work
University of Washington

TWENTIETH CENTURY COHORTS

Date Born	1960s	1950s	1940s	1930s	1920s	1900-1910s
Impressionable Years	1970s	1960s	1950s	1940s	1930s	1910-1920s
Age Now	30's	40's	50's	60's	70's	80-90's
Historical Events	Kent State 18 year old vote Anti-war riots Vietnam War ends Watergate Nixon/Agnew resign USA--200 years old Test tube baby Elvis dies Jonestown Suicide Disco Dancing Ecology Questioning of Welfare State Taxpayer Revolt Baby Boomers hit Job market Inflation World Unemployment Energy Crisis Hostage Crisis Recession	JFK elected Peace Corps Man in space Berlin Wall Bay of Pigs Ban School Prayer Beattles Bob Dylan Assassinations: JFK; Bobby K, M.L. King, Jr. LBJ - Great Society Vietnam The "Pill" Hippies Credit cards Cohabitation Women's Rights Civil Rights Alcohol/Drugs Recession New Left	Hydrogen Bomb Color TV Polio Vaccine Dr. Spock Supreme Court orders desegregation of schools/buses/ restaurants Baby Boom Sputnik Negroes - "Blacks" High Employment Economic Prosperity	France Falls Pearl Harbor Japanese/American Interned A-Bombs dropped Discovery of annihilation of 6,000,000 Jews Sound barrier broken Israel Recognized UN Chartered	Great Depression Homelessness Hunger SS Act Passed Germany invades Poland Penicillin Discovered 15,000,000 jobless	World War II Agarian Society Prohibition Women get vote First National Radio Network Talking Movies First Municipal Airport Stock Market Crash Suicides
Common Values, Attitudes, Behaviors	Morality of Wealth "Me" philosophy Focus on Quality of life	Greater Social Consciousness Disaffection Disillusionment Participation not authority	Child Focused Affluence Increased Sexual Freedom Increasing divorce Buying on credit	Unity Patriotism Anti-War Isolationist Women working Increasing Mobility	Deep appreciation of being employed and being able to support family Job security Hard work, achievement Materialism Self-sufficiency	Values; Hard work, family loyalty, authority, country Puritanism "Working together" "Stick it out" "Work for work's sake"

cohorts .543
hanneman2c

National Institute on Aging

What's Your Aging I.Q.?

	True	False
1. Baby boomers are the fastest growing segment of the population.	☐	☐
2. Families don't bother with their older relatives.	☐	☐
3. Everyone becomes confused or forgetful if they live long enough.	☐	☐
4. You can be too old to exercise.	☐	☐
5. Heart disease is a much bigger problem for older men than for older women.	☐	☐
6. The older you get, the less you sleep.	☐	☐
7. People should watch their weight as they age.	☐	☐
8. Most older people are depressed. Why shouldn't they be?	☐	☐
9. There's no point in screening older people for cancer because they can't be treated.	☐	☐
10. Older people take more medications than younger people.	☐	☐
11. People begin to lose interest in sex around age 55.	☐	☐
12. If your parents had Alzheimer's disease, you will inevitably get it.	☐	☐
13. Diet and exercise reduce the risk for osteoporosis.	☐	☐
14. As your body changes with age, so does your personality.	☐	☐
15. Older people might as well accept urinary accidents as a fact of life.	☐	☐
16. Suicide is mainly a problem for teenagers.	☐	☐
17. Falls and injuries "just happen" to older people.	☐	☐
18. Everybody gets cataracts.	☐	☐
19. Extremes of heat and cold can be especially dangerous for older people.	☐	☐
20. "You can't teach an old dog new tricks."	☐	☐

Answers

1. **False.**

There are more than 3 million Americans over the age of 85. That number is expected to quadruple by the year 2040, when there will be more than 12 million people in that age group. The population age 85 and older is the fastest growing age group in the U.S.

2 **False.**

Most older people live close to their children and see them often. Many live with their spouses. An estimated 80 percent of men and 60 percent of women live in family settings. Only 5 percent of the older population lives in nursing homes.

3. **False.**

Confusion and serious forgetfulness in old age can be caused by Alzheimer's disease or other conditions that result in irreversible damage to the brain. But at least 100 other problems can bring on the same symptoms. A minor head injury, high fever, poor nutrition, adverse drug reactions, and depression also can lead to confusion. These conditions are treatable, however, and the confusion they cause can be eliminated.

4. **False.**

Exercise at any age can help strengthen the heart and lungs and lower blood pressure. It also can improve muscle strength and, if carefully chosen, lessen bone loss with age. See a physician before beginning a new exercise program.

5. **False.**

The risk of heart disease increases dramatically for women after menopause. By age 65, both men and women have a one in three chance of showing symptoms. But risks can be significantly reduced by following a healthy diet and exercising.

6. **False.**

In later life, it's the quality of sleep that declines, not total sleep time. Researchers have found that sleep tends to become more fragmented as people age. A number of reports suggest that older people are less likely than younger people to stay awake throughout the day and that older people tend to take more naps than younger people.

7. **True.**

Most people gain weight as they age. Because of changes in the body and decreasing physical activity, older people usually need fewer calories. Still, a balanced diet is important. Older people require essential nutrients just like younger adults. You should be concerned about your weight if there has been an involuntary gain or loss of 10 pounds in the past 6 months.

8. **False.**

Most older people are not depressed. When it does occur, depression is treatable throughout the life cycle using a variety of approaches, such as family support, psychotherapy, or antidepressant medications. A physician can determine whether the depression is caused by medication an older person might be taking, by physical illness, stress, or other factors.

9. **False.**

Many older people can beat cancer, especially if it's found early. Over half of all cancers occur in people 65 and older, which means that screening for cancer in this age group is especially important.

10. **True.**

Older people often have a combination of conditions that require drugs. They consume 25 percent of all medications and can have

many more problems with adverse reactions. Check with your doctor to make sure all drugs and dosages are appropriate.

11. **False**.

Most older people can lead an active, satisfying sex life.

12. **False**.

The overwhelming number of people with Alzheimer's disease have not inherited the disorder. In a few families, scientists have seen an extremely high incidence of the disease and have identified genes in these families which they think may be responsible.

13. **True**.

Women are at particular risk for osteoporosis. They can help prevent bone loss by eating foods rich in calcium and exercising regularly throughout life. Foods such as milk and other dairy products, dark green leafy vegetables, salmon, sardines, and tofu promote new bone growth. Activities such as walking, biking, and simple exercises to strengthen the upper body also can be effective.

14. **False**.

Research has found that, except for the changes that can result from Alzheimer's disease and other forms of dementia, personality is one of the few constants of life. That is, you are likely to age much as you've lived.

15. **False**.

Urinary incontinence is a symptom, not a disease. Usually, it is caused by specific changes in body function that can result from infection, diseases, pregnancy, or the use of certain medications. A variety of treatment options are available for people who seek medical attention.

16. **False**.

Suicide is most prevalent among people age 65 and older. An older person's concern with suicide should be taken very seriously and professional help should be sought quickly.

17. **False**.

Falls are the most common cause of injuries among people over age 65. But many of these injuries, which result in broken bones, can be avoided. Regular vision and hearing tests and good safety habits can help prevent accidents. Knowing whether your medications affect balance and coordination also is a good idea.

18. **False**.

Not everyone gets cataracts, although a great many older people do. Some 18 percent of people between the ages of 65 and 74 have cataracts, while more than 40 percent of those between 75 and 85 have the problem. Cataracts can be treated very successfully with surgery; more than 90 percent of people say they can see better after the procedure.

19. **True**.

The body's thermostat tends to function less efficiently with age, making the older person's body less able to adapt to heat or cold.

20. **False**.

People at any age can learn new information and skills. Research indicates that older people can obtain new skills and improve old ones, including how to use a computer.

Palmore, E. Facts on Aging: A Short Quiz. The Gerontologist. Vol. 17, 315-320, 1977

FACTS ON AGING
A SHORT QUIZ

T	F	1.	The majority of persons age 65 are senile, have defective memory, and are disoriented.
T	F	2.	Older persons are not treatable because their mental conditions are inevitable and irreversible.
T	F	3.	Most older persons have no interest in or capacity for sexual relations.
T	F	4.	All five senses tend to decline in old age.
T	F	5.	Lung capacity tends to decline in old age.
T	F	6.	The majority of old people feel miserable all the time.
T	F	7.	Physical strength tends to decline in old age.
T	F	8.	At least one-tenth of the aged are living in long-stay institutions (nursing homes, homes for the aged, mental institutions).
T	F	9.	Most old people are set in their ways and unable to change.
T	F	10.	Old people usually take longer to learn something new.
T	F	11.	The reaction of most old people tends to be slower than that of younger people.
T	F	12.	In general, most old people are pretty much alike.
T	F	13.	The majority of old people are socially isolated and lonely.
T	F	14.	Over 15% of the U.S. population are now age 65 and older.
T	F	15.	Most medical practitioners tend to give the aged low priority.
T	F	16.	The majority of older people have incomes below the poverty level.
T	F	17.	Older people tend to become more religious as they age.

T F 18. The majority of older people are seldom irritated or angry.

T F 19. There are approximately four times as many widows as widowers.

T F 20. The health and socio-economic status of older people in the year 2000 (compared to younger people will probably be the same as now.

T F 21. Achievement in various scientific, artistic, and creative fields is highest in younger years and steadily decreases.

T F 22. Most elderly people can expect retirement to reduce their incomes by 50% or more.

T F 23. The elderly are more inclined to solve their problems on the basis of past experience or solutions rather than experimenting with new ones.

T F 24. With regard to mental functioning, many declines experienced by the elderly are not apparent except under stress conditions.

T F 25. Though older people often express awareness of death in conversations, they are not fearful of it.

T F 26. People naturally recognize when they are old.

T F 27. T.V. watching is more of a leisure pursuit for the elderly than for any other age group.

FACTS ON AGING QUIZ ANSWERS

F 1. Research indicates that loss of memory does not take place as part of healthy aging -- that is, when memory loss does occur, it generally is associated with some type of pathology (moderate to severe organic brain syndrome). Other reasons for memory loss may be:

1) Self-fulfilling prophecy (stereotype). We expect older people to forget - they expect to forget - so they do.
2) Social factors. People remember what is important and what is supportive of self-esteem. If the most important achievements and relationships occurred in the past and not much at all is occurring now, why not remember the past to the exclusion of the present?

F 2. Even in cases of irreversible organic brain disease, emotional and behavioral aspects can often be treated. It is our attitude toward mental decline in the elderly that prevents adequate treatment. Elderly are generally under-represented in mental health centers.

F 3. Interest remains well into seventies. Capacity for sex in healthy older persons also remains until late old age. Need for touch and intimacy remain.

T 4. Visual losses are usually most feared. Hearing loss often creates most social isolation and paranoia. (To see someone talking and not be able to hear.)

T 5. Lung capacity declines (about one percent each year from age 30 to 70).

F 6. Majority actually do quite well - though 86% have some type of chronic condition.

T 7. Variable with individual.

F 8. Four percent in nursing homes at any one time; 1% in other long-term care institutions (mental hospitalization); and up to 25% in a nursing facility at some time in their old age.

F 9. Most cope with age-associated changes as they have coped with other changes.

F 10. Can learn as well, but not as quickly. Practical judgment and creativity often increase.

T 11. Reaction time and nerve impulse speed slows.

F 12. Just the contrary - increased life experiences cause older people to be more different.

F 13. About 28% live alone or with non-relatives
67% in families
5% in institutions
82% of those who are unmarried live within 30 minutes of family.

F 14. 17-30% estimated by year 2000.
Peak at 2030-2050.
11.3% of the U.S. population now over 65.

T 15. The impact of this on care is evident. Older people are seen as hopeless.

F 16. According to the Senate Special Committee on Aging, one in four of the elderly are poor compared to one in nine in the younger population. Many of these people become poor after becoming old.

F 17. Depends on what you measure.

T 18. 1/2 said never or hardly ever irritated.
2/3 over age 80 said never or hardly ever irritated.

T 19. There are more males born, but by about age 25, women take over majority. Higher death rates for men throughout life.

F 20. Will probably be higher - gaps in health, income, education will be less.

F 21.

T 22.

T 23. Have had more experience to know what works, what doesn't. Coping styles seem to remain fairly stable.

T 24.

T 25. More fearful of painful dying than of death. Would like to be more free to talk about it.

F 26. See when others are old, not self.

F 27.

SURVEY OF FACTS AND ATTITUDES ON AGING

The survey on the following five pages was adapted by the Texas Consortium of Geriatric Education Centers from the following sources:

Part I. Kogan, Nathan. "Attitudes Toward Old People: The Development of a Scale and an Examination of Correlates." Journal of Abnormal and Social Psychology, Vol. 62, No. 1, 1961, pp. 44-54.

Part II. Palmore, Erdman. "Facts on Aging: A Short Quiz." The Gerontologist, Vol. 17, No. 4, 1977.

Part III. Merrill, J.M., et al. "Quantitating Medical Students' Attitudes Toward the Elderly." Society for Health and Human Values, Vol. 16 (6A), 1986.

SURVEY OF FACTS AND ATTITUDES ON AGING

INTRODUCTION: There exist several barriers to the effective delivery of needed caring services to the elderly citizens of our society. The items contained in this questionnaire are designed to ascertain the perceptions of individuals concerning the elderly. **PART I** is a reproduction of Kogan's Attitudes Towards Old People Scale using a six-point Likert scale for answering. **PART II** represents a reproduction of Palmore's Facts on Aging Quiz which incorporates a six-point response scale. Together, these two short surveys are designed to gather information about your perceptions of some basic physical, mental and social facts about aging. Together, the completion of both parts should take no more than twenty (20) minutes.

PART I: The following survey contains seventeen (17) paired responses concerning some aspect of aging. Read each item carefully, then select and circle the one answer that best represents your perception about what has been asked, using the following six-point Likert scale:

1 = Strongly Disagree (SD)
2 = Disagree (D)
3 = Moderately Disagree (MD)
4 = Moderately Agree (MA)
5 = Agree (A)
6 = Strongly Agree (SA)

	SD	D	MD	MA	A	SA
It would probably be better if most old people lived in residential units with people their own age.	1	2	3	4	5	6
It would probably be better if most old people lived in residential units that also housed younger people.	1	2	3	4	5	6
There is something different about most old people: it's hard to figure out what makes them tick.	1	2	3	4	5	6
Most old people are really no different from anybody else: they're as easy to understand as younger people.	1	2	3	4	5	6
Most old people get set in their ways and are unable to change.	1	2	3	4	5	6
Most old people are capable of new adjustments when the situation demands it.	1	2	3	4	5	6
Most old people would prefer to quit work as soon as pensions or their children can support them.	1	2	3	4	5	6
Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	1	2	3	4	5	6
Most old people tend to let their homes become shabby and unattractive.	1	2	3	4	5	6
Most old people can generally be counted on to maintain a clean, attractive home.	1	2	3	4	5	6
It is foolish to claim that wisdom comes with old age.	1	2	3	4	5	6
People grow wiser with the coming of old age.	1	2	3	4	5	6
Old people have too much power in business and politics.	1	2	3	4	5	6
Old people should have more power in business and politics.	1	2	3	4	5	6
Most old people make one feel at ease.	1	2	3	4	5	6
Most old people are very relaxing to be with.	1	2	3	4	5	6

Most old people bore others by their insistence on talking about the "good old days."	1	2	3	4	5	6
One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.	1	2	3	4	5	6
Most old people spend too much time prying into the affairs of others and giving unsought advice.	1	2	3	4	5	6
Most old people tend to keep to themselves and give advice only when asked.	1	2	3	4	5	6
If old people expect to be liked, their first step is to get rid of their irritating faults.	1	2	3	4	5	6
When you think about it, old people have the same faults as anybody else.	1	2	3	4	5	6
In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.	1	2	3	4	5	6
You can count on finding a nice residential neighborhood when there is a sizable number of old people living in it.	1	2	3	4	5	6
There are a few exceptions, but in general most old people are pretty much alike.	1	2	3	4	5	6
It is evident that most old people are very different from one another.	1	2	3	4	5	6
Most old people should be more concerned with their personal appearance; they're too untidy.	1	2	3	4	5	6
Most old people seem to be quite clean and neat in their personal appearance.	1	2	3	4	5	6
Most old people are irritable, grouchy, and unpleasant.	1	2	3	4	5	6
Most old people are cheerful, agreeable, and good humored.	1	2	3	4	5	6
Most old people are constantly complaining about the behavior of the younger generation.	1	2	3	4	5	6
One seldom hears old people complaining about the behavior of the younger generation.	1	2	3	4	5	6
Most old people make excessive demands for love and reassurance.	1	2	3	4	5	6
Most old people need no more love and reassurance than anyone else.	1	2	3	4	5	6

PART II: This section contains twenty-five (25) items. Read each item carefully, then select and circle the one answer that best represents your perception about what has been asked using the following six point Likert scale.

1 = Strongly Disagree (SD)
2 = Disagree (D)
3 = Moderately Disagree (MD)
4 = Moderately Agree (MA)
5 = Agree (A)
6 = Strongly Agree (SA)

	SD	D	MD	MA	A	SA
The majority of old people (past age 65) are senile (i.e., defective memory, disoriented, or demented.)	1	2	3	4	5	6

	SD	D	MD	MA	A	SA
All five senses tend to decline in old age.	1	2	3	4	5	6
Most old people have no interest in, or capacity for, sexual relations.	1	2	3	4	5	6
Lung capacity tends to decline in old age.	1	2	3	4	5	6
The majority of old people feel miserable most of the time.	1	2	3	4	5	6
Physical strength tends to decline in old age.	1	2	3	4	5	6
At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.).	1	2	3	4	5	6
Aged drivers have fewer accidents per person than drivers under age 65.	1	2	3	4	5	6
Most older workers cannot work as effectively as younger workers.	1	2	3	4	5	6
About 80% of the aged are healthy enough to carry out normal activities.	1	2	3	4	5	6
Most old people are set in their ways and unable to change.	1	2	3	4	5	6
Old people usually take longer to learn something new.	1	2	3	4	5	6
It is almost impossible for most old people to learn new things.	1	2	3	4	5	6
The reaction time of most old people tends to be slower than reaction time of younger people.	1	2	3	4	5	6
In general, most old people are pretty much alike.	1	2	3	4	5	6
The majority of old people are seldom bored.	1	2	3	4	5	6
The majority of old people are socially isolated and lonely.	1	2	3	4	5	6
Older workers have fewer accidents than younger workers.	1	2	3	4	5	6
Over 15% of the U.S. population are now age 65 or over.	1	2	3	4	5	6
Most medical practitioners tend to give low priority to the aged.	1	2	3	4	5	6
The majority of older people have incomes below the poverty level (as defined by the Federal Government).	1	2	3	4	5	6
The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).	1	2	3	4	5	6
Older people tend to become more religious as they age.	1	2	3	4	5	6
The majority of older people are seldom irritated or angry.	1	2	3	4	5	6
The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.	1	2	3	4	5	6

PART III. Please carefully select and circle the one answer that best represents your perception about how often you expect to find the thirty-nine (39) traits below in a geriatric person using the following five-point Likert scale:

Trait	Rarely	Occasionally	About Half the Time	Often	Almost Always
Absent-minded	1	2	3	4	5
Active	1	2	3	4	5
Adaptable	1	2	3	4	5
Alert	1	2	3	4	5
Bitter	1	2	3	4	5
Cheerful	1	2	3	4	5
Confused	1	2	3	4	5
Considerate	1	2	3	4	5
Cooperative	1	2	3	4	5
Demanding	1	2	3	4	5
Dependent	1	2	3	4	5
Dignified	1	2	3	4	5
Dissatisfied	1	2	3	4	5
Enthusiastic	1	2	3	4	5
Fault-finding	1	2	3	4	5
Fearful	1	2	3	4	5
Gloomy	1	2	3	4	5
Independent	1	2	3	4	5
Meek	1	2	3	4	5
Moody	1	2	3	4	5
Nagging	1	2	3	4	5
Obnoxious	1	2	3	4	5
Opinionated	1	2	3	4	5
Pessimistic	1	2	3	4	5
Pleasant	1	2	3	4	5
Quarrelsome	1	2	3	4	5
Quick	1	2	3	4	5
Reflective	1	2	3	4	5
Reliable	1	2	3	4	5
Resourceful	1	2	3	4	5
Rigid	1	2	3	4	5
Rude	1	2	3	4	5
Tactful	1	2	3	4	5
Trusting	1	2	3	4	5
Unkempt	1	2	3	4	5

Trait	Rarely	Occasionally	About Half the Time	Often	Almost Always
Unselfish	1	2	3	4	5
Warm	1	2	3	4	5
Whiny	1	2	3	4	5
Withdrawn	1	2	3	4	5

National Institute On Aging

WHAT'S ON YOUR MIND?
A Quiz on Aging and the Brain

1. "You can't teach an old dog new tricks" is a saying

   a. that recent scientific experiments have shown to be true for older people.
   b. that only applies to dogs, cats, and other nonhuman species.
   c. that is outdated and scientifically incorrect.

2. How does aging affect intelligence?

   a. Brains in older people don't work as fast, but knowledge based on experience grows in later life.
   b. Older people are really more intelligent because they have been using their brains for so many years.
   c. Older people learn significantly less than they did when they were younger.

3. Creativity in old age is

   a. enhanced by experience.
   b. a lost art.
   c. difficult because of changes in the brain.

4. Depression is a problem for many older people. The condition is

   a. acceptable, given their age and illnesses.
   b. just a normal part of growing older and is irreversible.
   c. frequently treatable once its cause is pinpointed.

5. Psychotherapy, or "talk" therapy, for people over age 65 is

   a. a waste of time. People that age don't have much time left.
   b. a good idea. At age 65, people continue to live a long time, making it even more important that they seek help for mental health problems.
   c. a waste of effort. Older people are so set in their ways that there really isn't much point in trying to deal with their mental health problems.

6. Nerve cells in the adult brain gradually die over the years. What is the result?

   a. It mean that significant memory loss in old age is inevitable.
   b. For most individuals, this doesn't mean much because people continue to learn as they grow older.
   c. Over time - and with a proper diet, physical exercise, and mental stimulation - the brain replenishes the nerve cells it loses.

7. Which of the following has been shown to cause Alzheimer's disease in some patients?

   a. Alcohol or drug abuse.
   b. Aluminum deposits in the brain.
   c. A genetic defect in some families.
   d. Lack of education.

8. Most typically, memory loss in older people is caused by

   a. Alzheimer's disease.
   b. too many things to remember.
   c. a variety of factors, such as overmedication or illness.

9. Which of the following is true?

   a. Alzheimer's disease can be cured if diagnosed early enough.
   b. Alzheimer's disease can be treated to slow the progress of the disease.
   c. There is no known cure for Alzheimer's disease.

10. What is the best method for conclusively diagnosing Alzheimer's disease?

   a. The Myers-Briggs personality test.
   b. A diagnostic blood test.
   c. Psychiatric evaluation.
   d. Tissue analysis after death.

11. True or False? - Solving puzzles and other "mental gymnastics" keeps the aging brain healthy.

   a. False. Mental exercises won't keep your brain sharp in later life.
   b. True. Intellectual and creative pursuits help adults avoid dementing diseases.
   c. Neither. While many scientists believe that mental exercises may be of value in maintaining health, the idea has yet to be formally demonstrated in studies of people as they age.

12. Personality changes in later life are

   a. rare in healthy people. People stay pretty much the same throughout life.
   b. normal because experience makes people very different than they were as children and young adults.
   c. inevitable because people become cranky and difficult as they age.

13. Dreading death is a preoccupation among

    a. older adults who, as they grow yet older, see friends dying.
    b. many healthy adults in middle age who are struggling with "midlife crisis."
    c. both of the above.

14. The risk of suicide for people age 65 and older is

    a. the lowest of all age groups.
    b. the highest of all age groups.
    c. too small to be measured.

15. True or False? - Older people worry too much.

    a. False. Worry is not really a characteristic of old age.
    b. True. People become much more anxious as they age.

16. A "tip-of-the-tongue" (TOT) experience - when you know a word or name but just can't seem to retrieve it from your memory -

    a. is always a sign of Alzheimer's disease in an older person.
    b. is usually a temporary glitch.
    c. means that once you have forgotten a name or word, you will never remember it again quickly.

17. Sexual problems in older adults

    a. are a normal part of aging. Women lose interest in sex after menopause and men are often impotent.
    b. are commonly caused by emotional or mental health problems.
    c. are caused by changes in brain function that affect parts of the brain associated with sexual satisfaction.

18. By the middle of the 21st century, unless research can bring new breakthroughs to cure Alzheimer's disease or delay its onset, the number of people with the disease is projected to reach

    a. the 1990 population of the Los Angeles metropolitan area (about 14 million).
    b. the 1990 population of the city of Chicago (almost 3 million).
    c. the 1990 population of the Philadelphia area (almost 6 million).

19. A stroke is a sudden disruption in the flow of blood to the brain. The likelihood of a stroke can be reduced.

    a. by quitting smoking, adopting sensible eating habits - low cholesterol and low fat diets - and controlling high blood pressure.
    b. by keeping under control and not allowing a bad temper to explode.
    c. somewhat. Research shows that the death rate from stroke has fallen only slightly despite preventive measures.

20. Many older people complain that they don't sleep as well as they used to. Their sleep may be troubled because

    a. they take more medications.
    b. they are anxious about retirement and other major life changes.
    c. they have a variety of medical problems, such as arthritis or cardiovascular disease, that are common with age.
    d. all of the above.

SOURCE: This quiz is based in large part on the work of National Institute on Aging scientists and grantees. This research has contributed to understanding that societal stereotypes about aging are based on confusion between what is normal aging and the diseases frequently associated with advancing age.

National Institute On Aging

WHAT'S ON YOUR MIND?
A Quiz on Aging and the Brain
Answers

1.c. Older adults can and do learn new skills relatively easily. In fact, in properly designed programs, older individuals can benefit from training as much as, and sometimes more than, younger people.

2.a. Experience-based intelligence remains stable or improves slightly well into late adulthood. In many jobs, the expertise of older workers allows them to be among the safest and most productive employees. The speed and efficiency of processing information can decline, however, with increasing age. Recent scientific experiments show that, with practice, older adults can reverse some of these effects.

3.a. Picasso painted until his death in his 90s, and Grandma Moses kept painting until she died at age 101. In addition, many not-so-famous older adults take on second or third careers, try new hobbies, or begin closer interpersonal relationships after age 65.

4.c. Depression can be treated successfully and should be taken seriously because it is a major risk factor for suicide. It is not a normal part of aging, although many older adults suffer from it. Adverse drug reactions, illness, certain life events, and other factors can cause older people to become depressed.

5.b. Psychotherapy ("talk" therapy) has proven successful for older people and its benefits can last for many years. At age 65, people continue to live an average of 16.8 years. Those over age 85 represent the fastest-growing age group.

6.b. It is true that nerve cell loss begins about age 2 and progresses throughout life. But normal nerve cell loss is not believed to have a significant effect on overall performance because people continue to learn as they age. Excessive nerve cell loss associated with illness can cause problems.

7.c. Studies indicate that a small but important percentage of Alzheimer's disease patients come from families in which the disease occurs more often than in the general population. This suggests that genetic factors play an important role in those families. Scientists have not yet been able to establish how much of a role genetics plays in the vast majority of families, however, and they have yet to identify other factors causing the disease.

8.c. Memory loss in older people can have many causes, and often can be treated. While Alzheimer's disease or other dementing disorders can cause memory loss, other factors can include depression, reactions to some drugs and head injury.

9.c. There is no known cure for Alzheimer's disease, but much can be done to treat the symptoms of the disease that cause suffering and discomfort. Several medical or social interventions can be used, including drug therapy for depression and simplifying the patient's environment.

10.d. A diagnosis of Alzheimer's disease can only be confirmed by autopsy after death. In the living patient, the diagnosis is strongly suggested only after all other possible causes of dementia are systematically ruled out.

11.c. Neither. While scientists have not proven that "mental gymnastics" keep an aging human brain healthy, they have found that there might be some benefit to "exercising" the brain. Laboratory research shows that animals in challenging environments can release chemicals in their brains, stimulating brain cells to produce new extensions that may help improve communication among cells.

12.a. When an older person shows significant personality or behavior changes, it is usually a signal that something else is wrong. For example, a new, growing hostility in relationships with others can mask serious, hidden depression.

13.b. A dread of death is not typical for healthy older adults. When it occurs in older people, it is usually related to depression or a struggle with terminal illness. In healthy adults, a fear of death is actually more common in middle age.

14.b. The risk of suicide rises with age. Older white males are the group most at risk.

15.a. False. For the vast majority of older adults, worry is not a problem. One recent study of people in their 90s found that over 70 percent report that they are in good spirits, never feel lonely, and are free from worry.

16.b. TOTs are often just temporary mental glitches, although word-finding problems may be slightly more frequent among older adults. Scientists are studying TOTs to see how the brains stores and retrieves information, hoping to explain a range of language and memory problems, such as those that occur after a stroke. In some cases, however, word-finding problems can be a sign of Alzheimer's disease. Older adults should be monitored closely to see if word finding becomes a serious difficulty.

17.b. Emotional state plays a greater role than normal aging changes in causing sexual problems in older adults. Depression can significantly interfere with sexual interest, motivation, and fantasy life in one's later years. It is one of the most common causes of impotence in older men and is treatable.

18.a. About 4 million people now have Alzheimer's disease. That number could exceed 14 million by 2040 without significant scientific progress on the causes of the disease and possible treatments.

19.a. These approaches have been so successful that the death rate from stroke has fallen as much as 50 percent since 1970. The decline also is due to more advanced diagnostic tests and treatments.

20.d. Although the quality of sleep can change as people age, most older people spend the same amount of time sleeping as they did when they were younger. Good sleep habits, including exercise, avoiding alcohol and caffeine, and going to sleep at the same time every night, can help with troubled sleep.

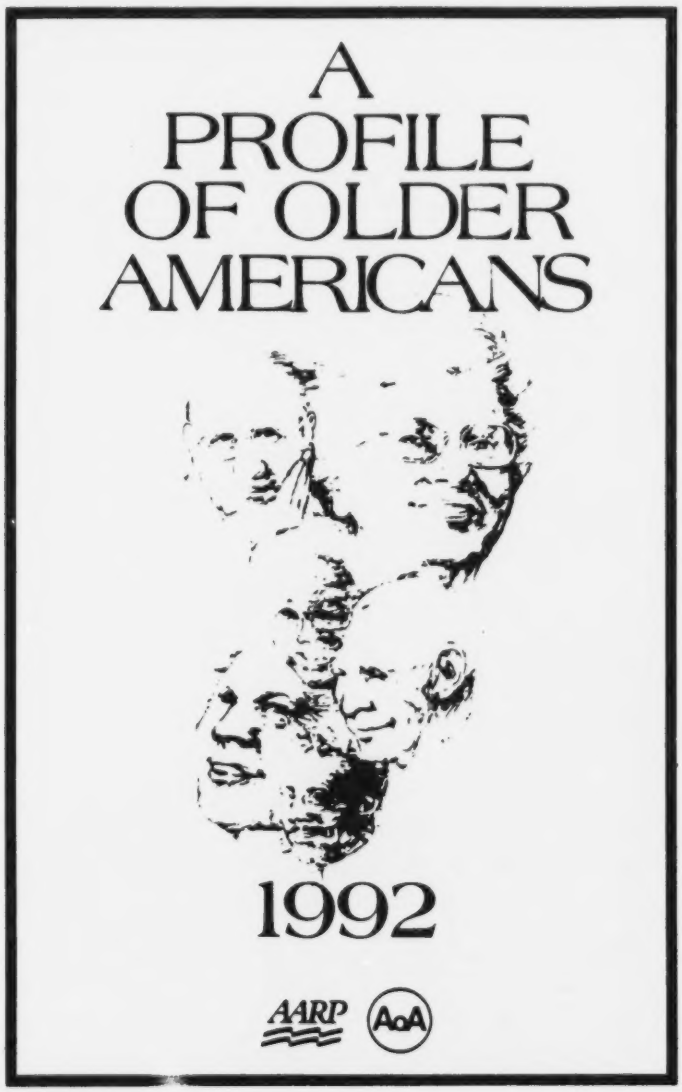
SOURCE: This quiz is based in large part on the work of National Institute on Aging scientists and grantees. This research has contributed to understanding that societal stereotypes about aging are based on confusion between what is normal aging and the diseases frequently associated with advancing age.

A PROFILE OF OLDER AMERICANS

A Profile of Older Americans: 1992 was prepared by the Program Resources Department, American Association of Retired Persons (AARP) and the Administration on Aging (AoA), U.S. Department of Health and Human Services.

This brochure includes information on: the size and age distribution of the older population, the marital status, living arrangements, and racial and ethnic composition of older people; the educational and economic status of older people as well as information on health care needs and housing.

Information was researched and compiled by Donald G. Fowles, AoA.
Production by Felo Madrid, AARP.



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Program Resources Department, American Association of Retired Persons, 601 E Street, N.W., Washington, D.C. 20049

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U.S. Bureau of the Census. Current Population Reports, Special Studies, P23-178, Sixty-Five Plus in American. U.S. Government Printing Office, Washington, DC, 1992.

CENSUS HIGHLIGHTS: SIXTY-FIVE PLUS IN AMERICA

Numerical Growth:

America is an aging society. In colonial times, half the population was under age 16; in 1990, less than 1 in 4 Americans were under age 16 and half were 33 or older; by 2050, at least half could be 43 or older. The 1990 census counted 31.1 million elderly (aged 65+), 12.5 percent of the total population. Among the elderly, 18 million were aged 75-84, and 3 million were 85 or older. The elderly population increased by 22 percent over the decade of the 1980's. We will experience undramatic growth of the older population from 1990-2010. From 2010-2030, however, the elderly population would grow 73 percent while the population under age 65 would decrease almost 3 percent (under middle series projections). By 2040, we could have more people aged 65+ than we have persons under 20 years of age. The U.S. had 6.9 million persons aged 80 or older in 1990 and that population could grow to more than 25 million by 2050. One in 35 Americans were 80 or older in 1990; by 2050, at least 1 in 12 could be 80+.

Centenarians, those who had reached the exceptional age of 100 years+, numbered 35,808 in 1990. The centenarian population more than doubled during the 1980's. This population group is 80 percent White and 79 percent female. Nine states had more than 1 million elderly in 1990. California had the largest number of persons aged 65+ (3.1 million). Florida had the largest proportion elderly (18 percent). From 1980-1990, America's oldest old population (85+) increased almost 38 percent. Eight states had more than 100,000 persons aged 85+ in 1990. Six percent of the world's population is elderly. Nearly 332 million persons were aged 65+ in the world in 1991. By the year 2000, there could be 426 million or more elderly. Over half the world's elderly live in developing nations.

Diversity of the Elderly Population:

We are beginning to see more racial diversity within the elderly population. In 1990, 1 in 10 elderly persons were races other than White. That could increase to about 2 in 10 by the middle of the next century. Additionally, we expect a greater proportion of the elderly will be persons of Hispanic origin (who may be of any race). About 1 in 5 elderly Blacks and Hispanics were 80 years or older in 1990. By 2050, these proportions could increase to about 1 in 3. The proportions for Whites are even higher. Elderly men are more likely than women to live in a family setting. After age 75, most men are married and living with their wives. Most women, however, are widowed and living alone. Life expectancy at birth in 1989 was 79 years for White females, 74 years for Black females, 73 years for White males, and 65 years for Black males. Poor health is not as prevalent as many assume, especially among the young old. Three in four noninstitutionalized persons aged 65 to 74 consider their health to

be good, very good, or excellent. The same is the case for 2 in 3 non-institutionalized persons aged 75+. Nine of ten non-institutionalized persons aged 65-74 reported they did not need personal assistance with everyday activities. Among those 85+, however, nearly 1 in 4 live in a nursing home. Of the nonistitutionalized oldest old, 45 percent needed personal assistance with everyday activities. Elderly women are likely to have long-term, chronic disabling diseases while men tend to develop relatively short-term fatal diseases. Income differences are significant for population subgroups. The 1990 poverty rates were higher for elderly Blacks (33.8$\pm$0.8 percent) and Hispanics (22.5$\pm$0.7 percent) than for Whites (10.1$\pm$0.5 percent). The educational attainment of the elderly population will increase significantly in the coming years because younger cohorts were more likely to have completed high school and attended college than is true for the elderly of today.

Implications:

The elderly of tomorrow will h[illegible]characteristics different from today's elderly. Such differences affect ultimate hea[illegible]nd economic status. Women are increasingly likely to have been in the labor force [illegible]ong enough to have retirement income in their own names. The lifetime experiences in employment and earnings for older Whites are different from older Blacks and Hispanics. This generally means fewer resources at retirement age for Blacks and Hispanics.

The four-generation family will be common. More of the young-old, while in their early years of retirement, will face the concern and expense of caring for very old, frail relatives. About 1 in 5 deaths occur after age 85. Under some projections, this proportion could more than double by 2050 due both to lower mortality and to the large number of surviving members of the Baby-Boom generation (those born between 1946-1964). This could affect the quality and financing of long lives. As medical technology advances, we can expect more people to live to the oldest ages but be chronic[illegible]lly ill and physically or mentally impaired. For many, the nature and duration of care could be more demanding than we have ever experienced. Where length of life has been an important societal issues in the past, quality of life (active life expectancy) is an issue of increasing importance. Women provide significant personal care to elderly family members. Some leave the work force to care for parents which can affect retirement benefits for their own old age.

SOCIAL WORK SPEAKS: NASW Policy Statements
2nd Edition

National Association of Social Workders, Inc.
7981 Eastern Avenue, Silver Spring, MD 20910

[redacted] Aging

BACKGROUND

The National Association of Social Workers (NASW) policy on aging is predicated on the following demographic and social characteristics and political and professional concerns.

Demographic Characteristics of Older People. Since 1900, the percentage of the U.S. population aged 65 years and older has increased from 4 percent to 13 percent (24 million). Among these older people, the 85-plus population is one of the fastest growing groups. In 1970, 0.7 percent (145,000) of the elderly population was over 85; by 2000, 1.4 percent (3.9 million) will be in this age group. The growth in this segment of older Americans has far-reaching implications for social and health policy. Older women outnumber older men three to two. This disparity, largely a result of women living longer than men, is expected to continue. Twenty-eight million elderly men and women are veterans, and the number of frail elderly veterans will increase fourfold by 2000. By 2030, the elderly will constitute at least 20 percent of the population, with the proportion of young and elderly people being almost equal. This phenomenon has been referred to as "squaring of the population pyramid." The increasing proportion of elderly people will have a significant impact on America's economic and social institutions.

Epidemiological data suggest that the aging of the population is an international phenomenon. Underdeveloped, or Third World, countries are also experiencing rapid rates of growth in their elderly populations, which are increasing three times faster than are the elderly populations in the "First World." These countries will be challenged to stretch meager resources to meet the needs of their elderly populations.

At birth, on the average, people of color have a shorter life expectancy than do white people. In some ethnic groups (blacks, for example) there may be what has been termed an "ethnic crossover." Some research suggests that by age 65, black men and women will outlive whites. As the life expectancy of people of color increases, there will be more elderly people in these groups. To be a person of color is to be in double jeopardy, for there is less likelihood of survival into old age and a greater likelihood of becoming a crime victim or of having an impoverished existence in later years. For example, 33 percent of elderly blacks live below the poverty line.

Economic Characteristics of Older People. The interrelationship between economic security and the capacity to meet basic living needs, particularly among impaired elderly people, makes people of color, the very old (aged 88 and older), and women especially vulnerable. Although the economic status of the elderly has improved since 1960 as a result of policy changes, the poverty rate for people aged 65 and older is still 14 percent (people of color have rates more than two times higher). This rate does not include the "hidden poor," the homeless elderly, and those living in nursing homes or with their families. In addition, a larger percentage of older people are just above the poverty line and thus at risk of poverty, often for the first time in their lives, because of the loss of income entailed by retirement, the inadequacy of private pension or social security benefits, the devastating consequences of the costs of health care and long-term care, or the loss of a spouse.

The median income of families headed by people aged 65 years or older is about two-thirds that of families headed by younger people. Such reduced income is not necessarily accompanied by the decreased need for food, housing, and health care, especially for elderly people who face inflation on a fixed income. Elderly people depend more heavily on social security than on any other source for their income.

Economic marginality is even more pronounced among elderly people who are women, who live alone, who are people of color, who live in rural areas, or who are older than age 75. It is also more pronounced for elderly people with chronic disabilities, who are mentally ill, or who have developmental disabilities. For example, women, particularly widows, constitute nearly 75 percent of the elderly poor. Of older people who are

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living alone, 43 percent are either poor or nearly poor. Among those older than age 85, nearly 40 percent are poor. The median income of older black and Hispanic men is about half that of white men aged 65 and older, and the poverty rate is highest among minority women living alone. Of the population older than age 65, 11 percent receive some type of public assistance through Supplemental Security Income (SSI) or Medicaid.

Social Characteristics of Older People. Older adults are a heterogeneous group with a wide range of physical and mental capabilities, financial resources, and preferences. Many elderly people aged 65 to 75 are healthy, experienced people with time and energy to participate in volunteer or paid activities, although some of them need training and support to undertake these activities. However, as they age, older Americans often have needs and problems that are related to their living arrangements, economic conditions, and physical limitations. Nearly two-thirds of older people live with family members, but more than one-third live alone or with nonrelatives. Living alone is especially a problem for older women, who represent 77 percent of the elderly who do so. The likelihood of living alone increases with age, and almost half those who are older than age 85 live alone. For some older people, living alone reflects their desire to remain independent and in their own homes. Unfortunately, this desire often is thwarted by the lack of adequate, affordable housing and in-home support services.

Although most older people live in their own households, most see a family member at least weekly. Despite myths that adult children have abandoned the elderly, families provide approximately 80 percent of the in-home care to those older than age 75 with chronic health problems. Often, younger and middle-aged family members, usually women, are forced to curtail or give up jobs to care for their elderly relatives. With the decline in the proportion of younger family members and the growth of four- and five-generation families, many family caregivers are themselves elderly, of low economic status, and in poor health. They frequently lack supports that would reduce the economic, physical, and emotional burdens they face from providing care. As the number of women in the work force continues to rise, the availability of caregivers may diminish.

Vulnerability of Older People. As a group, elderly people constitute one of the highest at-risk populations in the United States. Compared with younger people, the elderly are disproportionately vulnerable to chronic illness, functional disabilities, inadequate housing, crime, the loss of their spouses, and the loss of their social role. For example, of the top four chronic medical problems affecting the elderly, arthritis affects 500 out of 1,000 elderly people; hypertension, 400 out of 1,000; hearing problems, 300 out of 1,000; and heart problems, 300 out of 1,000. General use of medical care increases with age. Moreover, those within the overall population of people aged 75 years and older have extraordinary needs because frailty or functional disability frequently accompanies increasing age. For example, the proportion of elderly people who report difficulty with personal-care activities increases from 15 percent for those aged 65 to 69 to nearly 50 percent for those aged 85 years and older. Elder abuse is now seen as being a major problem for the elderly. Although there is no unified definition of abuse, statistics indicate that there are 100,000 new cases of abuse each year. It is also suggested that only one out of six cases is reported. Some figures suggest that 500,000 to 1.5 million older people are abused or neglected.

There are other major health–mental health problems for the elderly. Five percent of the elderly abuse substances, mostly alcohol. Twenty-five percent of the suicides in the United States are by elderly people. Two to four million persons have a progressive dementia. Accidental death rates for the elderly are twice the rate of all other groups; each year 23,000 elderly people die as the result of accidents. The number one cause of accidents in the elderly is falls. 25 percent of the accidents are caused by motor vehicles, and 10 percent are from burns. The elderly currently only receive 6 percent of the nation's mental health services.

Response of Society. This society has failed to address adequately the needs of older Americans. Some 95 percent of people older than age 65 now receive social security, SSI, or both, and Medicare and Medicaid help to pay for some acute health care costs, but many elderly people, when faced with the loss of a spouse or with chronic health problems, are unable to maintain an adequate standard of living. Although services have been made available to elderly people through the Social Services Block Grant (Title XX) of the Social Security Act (P.L. 89-73) and the Older Americans Act, they are often insufficient to meet the needs of many older people, particularly those who are most vulnerable in terms of their health, economic, and social status.

The problems and inadequacies of these well-intentioned benefits and services are well known. Funding is insufficient to serve adequately those who are in need. In some instances, a person's increase in benefits from one program eliminates his or her eligibility for other programs. Furthermore, older people frequently are un-

aware that they are eligible for certain benefits and services, and those who are nearly poor are often not poor enough to qualify for some financial benefits. Also, services are often fragmented and are not systematically coordinated.

The delivery of health care services to elderly people is also a concern. Health care dollar expenditures indicate that 13 percent of the elderly population utilize 30 percent of the health care dollars. Advances in medical technology have created ethical dilemmas related to who should live and for how long. There is also insensitivity to the social and psychosocial dimensions of illness. The development of long-term-care facilities has resulted in a dual system of care—institutionalization versus community-based care—without adequate funding for a continuum of care. Research has indicated that nursing-home placement is based more on the characteristics of the family-caregiver system than on the characteristics of the patient. Although institutionalization affects only 25 percent of the over-80 population, it is often feared as an end to personal autonomy and to a meaningful social role.

STATEMENT OF ISSUES

The social work profession is challenged to respond to the needs of a growing and changing heterogeneous elderly population. Although the socioeconomic circumstances of the elderly have improved to the extent that they no longer constitute the poorest age group, a significant number of older people are at high risk, particularly the burgeoning over-80 population, single women, and minorities. Impairing chronic illness, inadequate income, and the loss of social supports are the greatest threats to these groups. In contrast is the growing number of able older persons who, in the future, will be healthier and better educated than were their predecessors. They are a resource to be tapped, and productive opportunities for them must be forged. Negative attitudes about aging by the professional and lay communities continue to have an unfavorable impact on both able and disabled elderly people. Unless aggressively counteracted, these attitudes will forestall the implementation of effective changes.

Although the importance of gerontological social work is increasingly acknowledged in the literature, the social work profession must recognize its unique contribution to improving the quality of life for older Americans. Identifying the strengths of elderly people; providing supports to enhance functioning; and viewing the whole person from a combined biological, psychological, and social perspective, within the context of the family and larger environment, are social work values with applicability for the elderly. Specifically, the social work profession, in its practice, research, planning, and social policy formulations, must address the following issues:

- The urgency of developing and funding a coherent system of a long-term continuum of care that encompasses therapeutic, rehabilitative, and supportive goals in a variety of community and institutional settings
- The need for social supports, including social services and housing, to maintain older people in their homes and communities
- Disparities among the older population in the distribution of and access to health and social services
- Disparities between the older and younger populations with regard to the provision of mental health services
- The underutilization of the elderly as a resource to society
- The need to educate the public, professionals, and service providers on attitudes toward aging
- Recognition of the mutuality of support now enjoyed by the multigenerational family and the need to provide supports that enhance this reciprocity
- Recognition of the cultural heterogeneity among the elderly population and the need to provide culturally appropriate services
- Broadening the work force of gerontologically trained social workers
- Recognition of the constructive role that can be played by retirees within the profession and the need for long-range planning to ensure the security and participation of the growing number of retired social workers.

POLICY STATEMENT

A first guiding principle in policy development should be recognition of the intergenerational stake in providing adequate support for all dependent populations, including disabled, impoverished, and isolated elderly people. Such a perspective recognizes the interdependence of generations across the life span. It also acknowledges the importance of intergenerational alliances in obtaining public support to benefit the most needy, regardless of age, as well as to institute preventive and early intervention strategies to forestall social, economic, and health problems for all age groups. For example, social workers must vigorously oppose strategies that are designed to pit one generation against another as a means of dealing with the national budget deficit.

A second guiding principle is that all generations, including the elderly, should be afforded opportunities for vocational pursuits and personal growth.

Work Force Needs. There is a great need to invest in the training of social workers and to "train the trainers" on social work faculties. More opportunities must be provided for social workers trained in gerontology in state departments of aging and area agencies on aging and other related public and private entities.

Economic Security. As declared by the 1971 and 1981 White House Conference on Aging, there should be a minimum standard of income for elderly people, based on the intermediate budget as developed by the Bureau of Labor Statistics. Although social security should be the universal basic system for providing retirement income, other programs of retirement should be encouraged and integrated with it. The "retirement test" for social security, which penalizes recipients who want to continue employment, should be liberalized for older people who need or wish to augment their incomes. Any proposed changes in the Older Americans Act or other programs to implement fees for service should protect the access of low-income and minority elderly people to free and low-cost services.

The government must work to ensure the integrity of public, private, and commercial systems of economic security for elderly Americans. Efforts should be made to examine the merits of increasing, on an actuarial basis, the social security payments of those who retire after age 65. Efforts must be aimed at eliminating the adverse effects of interactions among programs that often result in an overall loss of benefits to people who are receiving assistance from two or more government-financed programs with separate and different requirements for eligibility. Social workers must also be sensitive to economic-security issues related to pension reform. Company takeovers, bankruptcies, and a change in marital status must not be allowed to threaten lifelong benefits to which workers are entitled.

Social and Support Services. A continuum of social services should be available to older people to enhance the functioning of and provide support to a diverse population. Services should be available to meet the needs resulting from the normal aging process, including life care and retirement planning. In addition, a range of services should be available to help elderly people with the losses of work, income, spouse, or friends that they may face. Such services as job programs, volunteer opportunities, senior centers, and support groups should be available. Older people should have the opportunity to participate in the widest range of civic, educational, recreational, and cultural activities.

Older people who are isolated, lonely, depres frail, or physically disabled also will require a range social and supportive services, including counseling vocacy, case management, and outreach. Protective vices are needed to ensure that older people who a vulnerable to victimization receive the support and sistance they need.

Both individual and group services should be av able. Services also should be available to help fam members of elderly people cope with the aging proc A broad range of services should be available to fa caregivers, including respite care, support groups, a assistance with direct care.

Social workers should play a leadership role in p ning and providing this broad range of social and su portive services. Programs should use informal hel networks, when possible. Multipurpose senior cer and day care centers should be maintained as foc points for services for the involvement of elderly peo

Rural Elderly People. Programs that address the cial needs of elderly people in rural areas should designed to fit their life-styles. Because growing old rural America presents unique problems in the de and delivery of services and outreach programs, b service programs of income support, employment, hou ing, health care, legal and protective services, and tr portation, among others, must be provided in ways are compatible with rural conditions, patterns, and tr ditions.

Minority Elderly People. A special effort mus made to ensure that services to elderly people meet t needs of minority populations. Many minority elder people are unable to gain access to the social ser system because of linguistic and cultural barriers. Th fore, the system must be flexible and comprehensi enough to meet the social, cultural, and care need minority elderly people. Minority representation n be increased at all levels of the social service syste and programs must recognize and reflect differences language, culture, and demographic and social cha teristics so that minority elderly people are not syste atically excluded from services. Furthermore, special e forts must be made to eliminate the extreme pov levels of minority elderly people.

Employment and Retirement. Although federal la specifies that discrimination on the basis of age is ille many forms of discrimination limit the use of older p ple's talents, skills, and experience for the good of then selves and their communities. With the "squaring of t population pyramid," older people will represent a v able pool of workers. Efforts should be made to bet use the skills of older people as employees and volu

teers. Training and employment programs must continue to address the needs of displaced homemakers—women who are too old to qualify for Aid to Families with Dependent Children but who do not yet qualify for social security. Compensation for elderly people who remain employed should be based on the prevalent community wage scale for comparable work. Benefit programs should allow for part-time jobs and volunteer jobs. Preretirement planning should be readily available to all employees. Special attention should be paid within the profession of social work to the needs of retired members of the National Association of Social Workers (NASW) and their full participation in the association's activities.

Health Care. An adequate system of health care for elderly people—going beyond Medicare, which is essentially a system of insurance for part of the cost of acute health care; catastrophic health insurance, which is limited to the cost of acute care; and Medicaid, which is a system of welfare medicine—must be developed as an integral part of a universal program of comprehensive health care available to all Americans. Such a comprehensive system should include full rehabilitative and preventative services, protection against overpayment, and funding for pharmaceuticals and prostheses. The vast resources of the Department of Veterans Affairs should be included as an integral part of the universal program.

Elderly people need to be informed about their rights and options regarding medical treatment. Social work, along with the other health care professions, must confront the ethical issues related to the use of life-sustaining medical technology.

Social work must develop clear policies related to euthanasia and must resist using chronological age as a criterion for withholding treatment. Support for the development of living wills will clarify individuals' wishes regarding the use of technology as a means to prolong life.

Long-Term Care. Social work must recognize that the long-term-care system cannot wait until society develops a comprehensive acute-care system. There is a critical need for long-term care that is available, affordable, and accessible in communities throughout the United States. Long-term care should encompass a continuum of care, including both institutional and community settings. The point of entry into the system must include a psychosocial assessment of the person, in which a professional social worker plays a major role and in which services and facilities are provided for those who are being screened. In assisting in the development of the continuum of care, the social worker must address the issues of maintenance of independence, self-determination, appropriate support systems, and the provision of adequate protective services. The goal is to develop and implement a long-term-care system that meets the needs of chronically impaired people, the majority of whom are elderly.

Older people should be sustained to the extent possible in their own environments. Thus, home health care, day programs, case management, and respite care must be available. Placement in an institution should be based on a person's need for health care, not on a simple calculation of costs. The quality of institutional care, when needed, must be maintained by adequate reimbursement and the regular review and monitoring of community-based board-and-care facilities, as well as the families of such persons. All long-term care and health services, including hospice services, should include a prominent social work component to help elderly people and their families cope. The importance of family caregivers as providers of long-term care must be recognized through education and support services, family and medical leave for relatives who care for elderly people, and tax and other financial benefits.

Mental Health. The mental health needs of elderly people should receive attention that is proportionate to their number through a comprehensive health care system. Community-based facilities must provide elderly people with equal access to mental health services. Adequate screening systems should be instituted to prevent inappropriate placement, and screening should be the gateway to available, appropriate services and facilities. Discharge planning and follow-up services should ensure the humane care and treatment of mentally impaired elderly people. The long-term-care needs of older people with mental impairments should be addressed within appropriate facilities. Staff, including nursing home staff, must receive training to meet the mental health needs of elderly people. This training should place special emphasis on cultural diversity.

Living Arrangements. A wide range of living arrangements should be available, designed, and located with reference to special needs and at costs that older people can afford. Sufficient housing should be available to provide older people with a choice. The public housing supply for lower- and middle-income older people must be increased. Funds for the maintenance and repair of housing should be readily available through a combination of grants and subsidized and conventional loans, as well as public funding of incentives for private investment. Laws must be developed to protect the assets of elderly people who choose to reside in retirement homes.

A range of supportive health and social services, such as home health, personal care, homemaker, friendly visiting, meals, and telephone reassurance, should be available to maintain older people in their homes and communities. Fire and safety codes should be established and enforced in all congregate facilities for older people. Subsidized congregate housing for elderly people should include social and supportive services. The public sector must fund incentives for the private sector to increase the supply of available housing.

Transportation. If elderly people are to benefit from available health and social services and other resources in a community, adequate transportation is necessary. Barrier-free transportation services must be established or expanded in urban and rural communities. Access[illegible] low-cost mass transit and special-purpose programs f[illegible] the elderly should be coordinated in the interest of s[illegible] ing the mobility requirements of elderly people.

Involvement of the Elderly. Older people should b[illegible] involved in every aspect of the planning, policy de[illegible] opment, administration, and evaluation of progra[illegible] including the deliberations of NASW. They should b[illegible] represented on all governing boards of agencies that a[illegible] designed to deliver services to the elderly. They mus[illegible] actively involved in the development of laws dealing w[illegible] ethical issues and the prolongation of life, as well as law[illegible] and programs that are designed to prevent elder ab[illegible] and to enhance health.

Policy statement approved by the NASW Delegate Assembly, August 1990. This statement supersedes th[illegible] policy statement on Aging approved by the Delegate Assembly in 1977.

For further information, contact the National Association of Social Workers, 7981 Eastern Avenue, Silver Spring, MD 20910. Telephone: 301-565-0333 or 800-638-8799.

AGING AND ETHNICITY

Annotated Bibliography by Racial/Ethnic Group

National Organizations Concerning Ethnic Aging

ANNOTATED BIBLIOGRAPHY BY RACIAL/ETHNIC GROUP

GENERAL:

National Association of Social Workers (1993). Social Work With Older People: Understanding Diversity.

The National Association of Social Workers (NASW) has developed this booklet to help social workers gain a better understanding of how to meet the needs of a rapidly growing diverse aging population. The booklet is intended as an overview, to identify the skills social workers may need, to raise issues that agencies must address, and to suggest some resources that may help social workers effectively and sensitively deal with their aging clients who come from many backgrounds and are a part of many cultural communities. Three case examples of older people with different cultural backgrounds are used to offer suggestions.

Yee, B.W.K. (1991). Variations in Aging: Older Minorities. Texas Consortium of Geriatric Education Centers, University of Texas Medical Branch at Galveston, (3rd ed.).

This curriculum module is designed to assist faculty in integrating information on older minority groups into an upper division undergraduate or graduate seminar in gerontology. The module includes lecture outlines; demographic and cultural characteristics; health and psychological status; social relationships; and recommended readings on African-American, American Indian, Asian and Pacific Island, and Hispanic Elder.

AFRICAN-AMERICAN/BLACK ELDERS:

Brown, D., Milburn, N., and Gary, L. (1992). Symptoms of Depression Among Older African-Americans: An Analysis of Gender Differences. The Gerontologist, 32(6), 189-795.

This study investigated the association between gender and depressive symptoms among 148 African-Americans who are 65 years of age and older; 79 females, 69 males. Although gender differences in depressive symptomology have been reported in the general populations, the results of this analysis found no gender differences in the overall level of depressive symptomology among African-Americans age 65+. Further analyses suggest that the lack of a gender difference in depressive symptoms was attributed to similarities in stressful life events.

Burton, L. (1992). Black Grandparents Rearing Children of Drug-Addicted Parents: Stressors, Outcomes and Social Service Needs. The Gerontologist, 32(6), 744-751.

This article reports findings from two studies of black grandparents and great-grandparents, age 43-82, who are rearing their children's children as a consequence of parental drug addiction. Although respondents found parenting their grandchildren an emotionally rewarding experience, they also incurred psychological, physical, and economic costs in performing their roles. Results also indicated that the grandparents and great-grandparents expected and relied on formal social service as a principle source of support.

Richardson, V. (1992). Service Use Among Urban African-American Elderly People. Social Work, 37(1), 47-54.

This paper examines factors associated with use of services among 186 urban African American elderly people. The article focuses on interviews with elders and the caregivers of the physically impaired older adults on availability of informal supports, knowledge of older-adult services and perceived need for older-adult services. Recommendations are made to enhance service utilization for African-American elderly people.

HISPANIC ELDERS:

Sanchez, C. (1992). Mental Health Issues: The Elderly Hispanic. Journal of Geriatric Psychiatry, XXV(1), 69-84.

This paper focuses on community mental health practice with Hispanics (Mexican, Puerto Rican, Cuban and other of Spanish/Hispanic origin) who are served by therapists unfamiliar with their needs. The article addresses the cultural factors, utilization, and needs for mental health services to Hispanics. Recommendations are made that will benefit therapists who serve the Hispanic population.

Purdy, J.K., Arguello, D. (1992). Hispanic Familism in Caretaking of Older Adults: Is It Functional? Journal of Gerontological Social Work, 19(2), 29-43.

This paper highlights a dysfunctional component within the Hispanic familial assistance pattern suggesting that familialism prevents use of formal services that the Hispanic elderly and caregivers desperately need. The authors purport that through an increased understanding of caregiver burden, professionals will be better prepared to intervene on behalf of the family. Specific intervention strategies aimed at increasing formal support usage within the Hispanic family unit are discussed.

ASIAN AND PACIFIC ISLANDER ELDERS:

Browne, C., Broderick, A. (1991). Aging and Ethnicity: A Replication Handbook for Social Work Education for Practice with Asian and Pacific Island Elders. Pacific Gerontology Social Work Education Curriculum Replication Project, University of Hawaii at Manoa, School of Social Work.

This handbook is designed for social work educators interested in preparing students for social work practice with Asian and Pacific Island elders. (Asian and Pacific American population is the nation's fastest growing minority group.) The handbook focuses on providing faculty with preparatory information and strategies to guide their work in the implementation of a multicultural gerontology curriculum that is responsive to elders in their respective communities.

Salauye, K. (1992). The Elderly Asian Patient. Journal of Geriatric Psychiatry, XXV(1), 85-104.

This paper reviews findings from the clinical literature about the mental health problems facing Asian elderly. The discussion is not of specific ethnic groups because there is limited information on mental health concerns of Asian elderly groups. An attempt is made to understand the diagnostic and treatment issues of Asian elderly groups, as it relates to foreign-born Asians; barriers to treatment for both foreign-born and American-born Asians; and biological differences.

Tran, T. (1992). Adjustment Among Different Age and Ethnic Groups of Indochinese in the United States. The Gerontologist, 32(4), 508-518.

This study examines adjustment among different age and ethnic groups of Indochinese refugees (including Vietnamese, Laotian, and Chinese Vietnamese) in the United States. 3,414 respondents were divided into four age groups for comparison: 20-29; 30-39; 40-54; and 55 and older. Results indicated that education, occupational status, urban/rural location in the country of origin, English language ability, financial problems, gender, age, and length of residence in the U.S. were related to adjustment in different age and ethnic groups. Implications for social service providers of these populations is discussed.

NATIONAL ORGANIZATIONS CONCERNING ETHNIC AGING

National Caucus and Center on Black Aged
Suite 500
1424 K Street NW
Washington, DC 20005
(202) 637-8400

National Indian Council on Aging
P.O. Box 2088
Albuquerque, NM 87103
(505) 242-9505

Associacion Nacional Pro Personas Mayores
3325 Wilshire Blvd., Suite 800
Los Angeles, CA 90010
(213) 487-1922

National Association for Hispanic Elderly
Suite 270
2727 West Sixth Street
Los Angeles, CA 90057
(213) 487-1922

National Hispanic Council on Aging
2713 Ontario Road NW
Washington, DC 20009
(202) 265-1288

National Pacific/Asian Resource Center on Aging
Suite 410
2033 Sixth Avenue
Seattle, WA 98121-2524
(206) 448-0313

National Resource Center on Minority Aging Population
San Diego State University Center on Aging
College of Health and Human Services
San Diego, CA 92102-0273
(619) 594-6989

Organization of Chinese Americans
Suite 926
2025 Eye Street NW
Washington, DC 20006
(202) 223-5500

Japanese-American Citizens League
1765 Sutter Street
San Francisco, CA 94115
(415) 921-5225

COMMUNICATION AND INTERVIEWING SKILLS

"Interviewing the Ill Aged" -- M. Bloom, et. al.

"Honoring the Client's Resistance" - Outline -- E. Teyber

Validation Therapy Overview -- N. Feil

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"Interviewing the Ill Aged," by Martin Bloom, et. al., from The Gerontologist,
Winter 1971, Part I, pp. 292-299.

Strategies are outlined for maximizing medical/social data collection by non-medically trained interviewers and minimizing stress to participants with mental and physical limitations. The problem areas include limitations in hearing, vision, language function, mobility, and balance, and complications related to balance, pain, fatigue, emotionality, and mentation.

Interviewing the Ill Aged[1]

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Social research should be conducted in accordance with two fundamentally interrelated values: The continuing search for objectively verified scientific knowledge and the continuing sensitivity to, and responsibility for, the well-being of the participant involved. This paper concerns interviewing ill adults whose problems may be chronic or acute, physical or mental, single or multiple. All of these types of problems present the interviewer with a need for a special sensitivity to the stress which any interviewing process inevitably poses. Each ill person needs to be understood in terms of his particular limitations but also in terms of his available strengths, so that the interviewer can more nearly attain the twin goals of maximizing data collection and minimizing stress for the person involved.

The purpose of this paper is to inform the non-medically trained interviewer about the types of difficulties ill persons face and to provide several methods for dealing effectively yet responsibly with these difficulties in order to obtain scientific information. The amount of information presented here has been strictly limited to whatever is of direct utility to the interviewing process or to the necessary background toward that end. Obviously, for more complete information about medical considerations or general interviewing practice, the reader is directed to standard texts and to easily available popular materials such as the American Heart Association booklets on stroke (see Cannell & Kahn, 1968; Shaffer, Sawyer, McClusky, & Beck, 1967; Taber; 1969; Webb, Campbell, Schwartz, & Sechrest, 1966).

This paper identifies nine general limitations of physical and/or mental functioning commonly found in ill persons. Four sections follow each: *(a)* the limitations will be *described behaviorally* as they would appear to an interviewer: *(b)* the *diseases* which commonly cause this functional problem will be given: *(c)* the *meaning of the limitation* to the ill person will be suggested because this is important in knowing how to

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approach him; *(d)* a set of *research interviewing strategies* will be presented to overcome the limitations while at the same time lessening stress to the ill person (see also Travis, 1966).

Limitations in Hearing

Behavior.—Hearing limitations may be detected by the presence of a hearing aid or by other behavioral cues, such as the person who seems to be inattentive or who has a strained facial expression particularly when listening. He may lean toward the interviewer with his "good" side, tilt his head, or cup his hands behind his ear. Or he may show none of these behavioral signs but merely answer a question inappropriately or ask the interviewer to repeat the question.

Diseases.—Many generalized diseases affect hearing. There are also many diseases specific to the ear including otosclerosis, Meniere's disease, mastoiditis, ototis media. These often cause hearing loss—especially in the present aged population who did not escape infection or have antibiotics when they were younger. Inner ear nerve damage from trauma, drugs, or infection is not correctable with mechanical devices. There is also hearing loss in some stroke patients (from brain damage) since the person may have lost the meanings for the words his ears hear.

Meaning.—Being limited in any sensory modality presents numerous problems in otherwise routine events. Deafness is socially isolating to some measure, resulting in possible danger and/or humiliation. The deaf person may tire easily or show annoyance because of pain or auditory blurring when the interviewer speaks *too loudly*. It requires a great deal of effort for the hard-of-hearing person to listen and to sort and file sounds into meaningful thoughts, especially when the conversation and the interviewer are both strange to him. Therefore, he may tire and may even give up the effort—especially if it is not in any way rewarding to him. It is not well understood by the non-deaf that wearing a hearing aid is sometimes uncomfortable and presents difficulties in adjusting the equipment. Moreover the sounds heard are not normal sounds in the same sense that eye glasses correct visual problems into normal vision.

Strategy.—In interviewing a person who has a hearing difficulty, the interviewer should speak in a *normal* voice, always talking directly to the person, making sure that the speaker's face is in clear light. This helps the client to read lips. The interviewer should also speak clearly, but should not accentuate words; he should avoid smoking and covering his mouth while speaking. If the older person has glasses, he should wear them since seeing tends to facilitate hearing. If the client is wearing a hearing aid, the interviewer should wait until he adjusts it before speaking. If it is possible to speak slowly without becoming strained or artificial, the interviewer should do so. There may be a lag between the reception of sound by an inadequate ear or nerve and the decoding of the sounds by the brain of the hard-of-hearing person. A hearing aid magnifies all sounds surrounding the client. It is important to minimize extraneous noises such as a TV playing in the next room, other conversations nearby, or the rustling of papers.

The interviewer should give the person a chance to repeat the question to make sure that he has heard it clearly. The clearer, shorter, and simpler the question, the better the chance that it will be successfully communicated. If the older person does not understand what is being said, the interviewer might try alternative ways of expressing the questions, because some words are difficult to "see" in lip reading. Other modalities should be used when possible, like nodding or pointing, to reinforce what has been said. It is likewise useful to have a written form of the questionnaire which a deaf person can read for himself, or at least come prepared with a pencil and paper to be able to write questions if necessary.

Limitations in Vision

Behavior.—Difficulties in vision of the interviewee may be identified by the presence of thick or dark glasses, a cloudy film over the eyes, or other discoloration in the eyes. However, some visual problems have no obvious signs, and the interviewer is left to infer visual limitations by the manner of the client's mobility, balance, etc.

Diseases.—There are three conditions which cause most of the limited vision of the aged: glaucoma (increased interocular pressure), cataracts (opacity of the lens of the eye or of its capsule), and hemianopia (defective vision in half the visual field).

Meaning.—The person with visual loss may be fearful, distrusting, and awkward in movements. He depends upon immediate sounds and tactile sensations to maintain his sense of security. With some types of visual problems, the person may

be in pain or nauseated, have visual field deficit, or be subject to visual distortion.

Strategy.—The interviewer should be careful that objects to be seen by the client are held within an area in which he has ability to see—in the center, for the person with glaucoma; at the edge, for the person with cataract; and on the side (the right or the left half of the visual field) which the person with hemianopia sees. The person who is blind, contrary to popular assumption, does not automatically use his other senses more intensely. He must be taught to use his other senses to better advantage.

The interviewer should maximize the use of the other senses by speaking clearly and distinctly in order to announce his presence and credentials. The tone of voice conveys much information usually obtained by seeing someone. A calm, quiet reassuring voice is most effective in establishing rapport.

Shaking hands as a physical contact may be very useful and expressive. However, it is probably upsetting to the older person who cannot see to be touched without being spoken to first. The interviewer should maximize whatever visual acuity is present by keeping out of the glare and by sitting in a place where the client can see the interviewer to the best of his ability.

One form of visual loss may not preclude another form of visual performance. For example, with blurring or tunnel vision, the older person may still be able to discriminate among objects, although he may need gentle encouragement to attempt a visual problem outside of the area where his own deficit exists. In general, a person who always needs glasses should be wearing them; otherwise his other senses will be dulled. Aged persons in particular rely on visual clues to hearing—often more than they realize.

Limitations in Language Functon

Behavior.—Difficulties in producing language are immediately evident as the person attempts to speak. Difficulty in understanding language is a separate issue, although it may be associated with difficulty in producing meaningful word patterns. Inconsistency or inappropriate response is the best way to identify the latter aspect of language limitations, although these responses may be caused by other limitations as well. It is important to note that difficulty in producing and understanding language varies in degree and kind. For one person a narrow range of language loss may be evident; for another, almost all may be lost. The aphasic (that is, the person with interference in the use or understanding of language) may be unable to form words, although he knows what he wants to say. Or he may be unable to comprehend what is said to him, or both. As language is the major vehicle for abstract thinking and judgment, limitations in language or understanding may give an artificially poor picture of the person's intelligence and personality.

Diseases.—Diseases such as amyotropic lateral sclerosis (a disease marked by the hardening of the lateral columns of the spinal cord with muscular atrophy), Huntington's chorea (characterized by chronic occurrence of a wide variety of jerky but well coordinated movements, performed involuntarily), multiple sclerosis (sclerosis occurring in sporadic patches throughout the brain and/or spinal cord), and Parkinson's disease (a neurological disease marked by tremors of resting muscles, slowing of voluntary movements, masklike face, festinating gait) often affect the ability to produce the spoken word due to inadequate muscular functioning. The Parkinsonian, for example, begins speech adequately but loses breath and by the end of the sentence may be inaudible. The person with a stroke, on the other hand, has a loss within his brain. These problems may also involve loss of muscle control if he has paralysis of this nature. There is also the problem of temporary voice loss after laryngectomy. However, these persons often can hear well and write a response.

Meaning.—Persons with aphasia are especially sensitive to the attitude and moods of others and may become irritated over minor incidents. Frustration is often present at the inability to communicate. There may be marked loss of self-confidence and self-worth.

Strategy.—Patience and planned stimulation are the keys to communication with aphasics. A person with language problems will speak better if he initiates the conversation with a listener with whom he feels comfortable in a familiar and unhurried environment. He will understand better if he can see the speaker and if he knows what is expected of him. Most importantly, the interviewer must give him time to understand and to respond, without applying pressure.

Communication will be improved if the aphasic is given visual cues and gestures to accompany the words. Again, the shorter and clearer the words, the more likely the meaning will be communicated. It is also important that the older person be given as many non-spoken

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cues as are appropriate. For example, the interviewer may pantomime an action being discussed, or hold or touch the object mentioned. It is also helpful to use sounds other than words to give the person clues about meaning. For example, the older person might not understand "pen," but he might understand the little snapping sound a ballpoint pen makes when the point is released.

Understanding the "broken" speech of some aphasics becomes easier as the interviewer listens carefully and builds up an understanding of how the older person communicates. The context of the questions will help. The interviewer should encourage the aphasic to communicate, even though it is slow going and the interviewer may not understand all that is being said, so long as the meaning is communicated. The interviewer should nod when he understands, but be attentive (not discouraging) when he does not. This interest and concern will help the aphasic's recovery without any contamination to the immediate interview. As a double check on the meaning of what the aphasic has said, the interviewer can reword his understanding of the meaning: "In other words, you would say that. . . ."

Limitations in Mobility

Behavior.—Identification of limitations in mobility, or paralysis, is made by noting the lack of movement of an affected limb or body part together with a set of rigid posture or complete lack of muscle function. Possibly physical props like a plaster cast or a pillow under an arm or special equipment like a "walker" may be present.

Diseases.—There are diseases such as Parkinsonianism, arthritis, stroke, fractures, and multiple sclerosis, which cause difficulty in mobility. There is visual information about these diseases whereas there are other diseases which cause no obvious damage that would lead the interviewer to expect limitations in moving about. Emphysema, pernicious anemia, and severe cardiac damage, often leave the person with limited energy for mobility. Sometimes this is so extreme that moving the hands or lifting objects (such as a notebook) exhausts the patient's reserve.

Meaning.—The ability to move about at will and to control one's actions is precious to every human being. When a person has limitations in some aspect of mobility, certain coordinated movements become difficult for the person to perform independently or it becomes difficult for him to predict his own movements. This can be very stressful; such persons may show irritability, defensiveness or fear. They are sensitive to close observation of, or comment about, peculiarities in gait, mannerism, or loss of control. However, some persons may want to treat their problem objectively and frankly. The interviewer should follow the person's lead in this matter. Part of the older person's embarrassment comes from the uncomfortable feelings which the interviewer exhibits.

Reactions to limitations are variable. One person may look upon tremors as "part of the disease" while another person may hold down his trembling limb during the interview out of embarrassment—and hence become overfatigued while apparently sitting in a restful position. Moreover, many simple events may distract the person because even routine things like getting to the toilet now require more time, effort, help, and planning.

Strategies.—The interviewer should be careful about the physical arrangements of the interview—seating, lighting, the availability of a table on which to spread materials if necessary—so as to minimize the need for the older person to move or to perform on his affected side. All this takes but a moment as the interviewer enters the room. For instance, if there is paralysis on the right side, sit on the left so that the left hand can be used for pointing, gesturing, and so forth. The pace of the interview must take into consideration the older person's limitations. He should not be allowed to tire, although he should be encouraged to use whatever level of mobility he has attained.

Problems Related to Balance

Behavior.—Unlike the problems discussed in the previous sections, problems of balance may not be easy to detect, although these problems may impose great difficulties on the older person. Clues include slowness or unsteadiness in any type of behavior, or when things not normally used for support are grasped firmly by the older person.

Diseases.—Some problems of balance are due to a lack of correct input into the brain, as, for example, in tertiary syphilis (late stage of syphilis characterized by a set of peculiar skin affections, bone lesions, and/or extensive disease of internal viscera) or pernicious anemia (non-nutritional anemia with damage to ascending tracts of the spinal cord). These persons have to use a tripod

gait (usually with a cane) in order to maintain balance. Persons with Meniere's disease can suddenly without warning have such severe vertigo (the room appears to wheel around) that they cannnot balance or walk. Arteriosclerotic patients are subject to constant or intermittent loss of a feeling of balance or may be dizzy. Parkinsonians have a characteristic leaning forward posture and can lose their balance and fall, or because of their shuffling gait they fall on rugs or small level changes. Arthritics tend to balance their weight on the less painful extremity and have difficulty walking over changing surfaces or on unlevel surfaces. Stroke patients have similar balance problems because of the inequality of weight between the strong and weak sides of their bodies.

Meaning.—Difficulties in balance are very terrifying and produce considerable insecurity. There may also be distortion in the perception of objects. Persons with problems of balance need to move very slowly and to achieve stability *before* and *after* moving.

Strategy.—The pace of the interview will have to be slowed down in order not to upset the person. Most of these persons can take auditory cues, but these should be given in a soft voice. Loud noises or sharp sounds should be avoided. Bright colors or rapid motions and other intense stimuli should be minimized. The interviewer should present objects for the person's examination slowly and quietly—not move them quickly or allow them to reflect light into his eves. Also, it may be necessary to present objects in such a way that the person can see them without any postural adjustment.

Pain: Severity, Frequency, and Location

Behavior.—There are both cultural and biological determinants to the way pain is felt and expressed. Some bear pain silently, but show a drawn face, beads of perspiration, abnormally rapid breathing, or perhaps an unusual posture which protects or reduces pain. Others express pain verbally as well. Still others may verbalize more pain than the actual situation would seem to necessitate. The longer the pain is present, the less the capacity to tolerate pain. Likewise, different locations involve different levels of tolerance. In general, people vary greatly concerning pain, but it is usually very easy to identify. It is more difficult to determine how to approach the person in pain.

Diseases.—All diseases have some kind of pain or discomfort. Very often, chronic pain regardless of intensity, is remarkably well tolerated, while acute pain and intermittent pain are poorly tolerated.

Meaning.—There are, then, many meanings of pain for the interviewer. Severe pain may be considered reason for stopping an interview; however, for some persons an interview may act to distract the person from his pain. Questions about the validity of the responses of a person in pain should be considered—is he able to give a true picture of his general opinions or of facts, uncolored by the pain? Also questions of reliability—would his opinions and facts be the same if he were interviewed at another time when he was not in pain? Mention should be made of the fact that medications given to reduce pain may have important side effects on the mental clarity and emotional tone of the person. If any of these problems have an adverse effect on the purpose of the interview, it would be better to reschedule it for another time.

Strategy.—A person in pain is susceptible to distraction. This tends to lessen his perception of his pain, provided the pain is not at an intolerable level, in which case attempts at diversion may increase the tension of the person. Because of the individual variation in feeling and expression of pain, the interviewer should openly discuss the problem with the person when appropriate, recognizing that it is difficult to answer questions under these conditions, but trying to motivate the person's interest. The interviewer might ask if the person would like to try some questions to see whether his attention might become concentrated on these rather than on the pain.

The interviewer should be attentive to the person's reactions, but he should not continually remind him of his pain. If the older person gives additional signs of discomfort, the interview might be postponed. The person in pain needs time to answer, but an over-long delay may mean that the task is overtiring him.

The matter of empathy for the person in pain may be a problem for some interviewers, where the empathy interferes with obtaining information. It is preferable that the interviewer admit this problem and limit the interview rather than to collect data that are invalid.

Fatigue

Behavior.—Normal fatigue appears only after strenuous or boring work, and a rest period rapidly restores the person's feeling of well-being as well as his capacity for other activities. In

the case of disease-related fatigue, the person frequently arises from a long rest period more fatigued than ever. Fatigue is identifiable in many ways—among them are diffuse physical weariness, low level of energy, postural changes, changes in facial expression, even sighing or grunting sounds, and perhaps sleepiness. There may also be lowered motivation and mental dullness and inattentiveness. Aged persons have a different pattern of fatigue from younger adults; aged persons fatigue more quickly and take longer time to replenish their energies.

Diseases.—Fatigue is part of most illnesses and also may result as a side effect of some drugs. Stressful fatigue is particularly evident in a person's adjusting to sensory deficits, mobility problems, and balance problems. Communicating with others, especially strangers, is likewise fatiguing.

Metabolic disturbances, such as myxedema, (extreme hypothyroidism), may be accompanied by unstressful fatigue on the part of the older person. This type of fatigue and dullness makes interviewing almost impossible. This fatigue is evidenced by the older person's apathy and loss of motivation.

Meaning.—The person who is fatigued may not be aware of this feeling, but it may be evidenced by a lowering of patience, interest, and poor performance or omission of social amenities. More often, the person is aware of fatigue, of feeling tired or without energy, and would appreciate being given the chance to talk at some later time.

Strategies.—The first problem is to identify the source of the fatigue. If there is some substantial reason for fatigue, that is if it is pathologically caused, then it would be best to make another appointment. If the fatigue emerges from having recently performed strenuous exercises or from boredom with the interview itself, then a short break might be sufficient time to allow the person to regain his energies in order to continue the interview.

Timing is an important consideration. The interview should be planned for optimal times during the day, not too early in the morning for some older persons, not too close to meal times, or when other appointments are due (as ill persons get anxious to be ready for the other events), and not after exhausting exercises or treatments. Aged adults may need a period of relaxation after sleep in order to become fully reoriented and able to participate in the interview. This does not leave much time, especially for hospitalized persons.

To recognize and to be considerate of another person's fatigue is a common courtesy and it also helps to build rapport for the follow-up interviews, if there are to be any.

Emotionality

Behavior.—Emotionality covers a very wide range of expressions of behavior. In general, these have in common the fact that the person's feelings are playing a more important part in directing his behavior than are his planned thoughts. Emotions tend to be short-run, hedonic, and self-centered (although other emotions are not excluded such as passionate commitments, self-hatreds). There tends to be a disproportionate expression of feelings as a guide to action. Emotional lability (the sudden change of mood) or a chronic state of fixity of emotion (such as constant depression or flattened affect) may be exhibited.

Emotions are a part of all personality functioning. Greater emotionality may be characteristic of some persons, just as suppression or control of emotions may be characteristics of others. Emotionality connected to illness means even greater presence of feeling than usual, as a reaction to any illness or event. The focus is often directed toward the self. Expression of emotions is culturally and socially influenced, but when illness is present it takes greater energy than the person may have available to control their normal expression.

Diseases.—As in pain, emotionality is a social and cultural expression and is evident in all disease. There is more emotionality expressed in diseases which threaten normal functioning of activities of daily living. For example, loss of bladder control or permanent bowel colostomies require great adaptation and are often socially and psychologically embarrassing to the person. Paralysis or permanent loss of mobility due to severe heart disease are more threatening to the self-image because of the physical drain on the body. A stroke patient or any disease involving brain damage may lead to a physically caused emotionality rather than an emotionality of psychological or social origin.

Meaning.—Some persons are not fully aware of their own emotional style and may not be aware of any changes due to illness. However, in other persons, there may be great awareness of changes in emotional reactions. For instance, the person who cries as part of the physiological

reaction in stroke is usually embarrassed, but occasionally a person may say to the interviewer, "Don't mind this crying, it's just part of the illness."

Strategies.—In general, the interviewer must be adaptive in the face of emotionality which is disruptive to the interview. A quiet pause may be sufficient to help the person regain control and to continue on with the questions. A thoughtful word or gesture may also convey the interviewer's feeling that the person's emotional feelings are understandable.

The sick role, especially for the chronically ill, is a difficult role for most persons to play. If, in addition, the illness is characterized by exacerbations and remissions, the patient is required to change roles often. Added to this the special role of participant in an interview situation may impose difficulties which the person is not able to handle without aid. The thought that the older person is contributing to the growth of important information—and the research should be significant enough to warrant interviewing of the ill—may be helpful if clearly presented and if permissible by the research design.

When the older person is very apathetic or disoriented, it is very important to spend the time to make a thorough attempt to communicate. A great deal of patience is needed, in asking a question, in waiting, in responding approvingly when some gesture or word is forthcoming. Such patience is often rewarded, especially in institutional settings where such patience may not be possible from the staff. If the interview fails, nothing but a few minutes is lost in the attempt to respect the dignity of a human being. The successes are all the more meaningful when they occur.

Problems in Mentation

Behavior.—Problems in mentation occur in one, or combinations, of the following areas: orientation, memory, comprehension, judgment, and integration of facts and ideas. Orientation concerns the ability to know one's self in relation to other persons, places, and in time. Problems in orientation are most often revealed as the person talks. Memory involves recall of immediate as well as remote experiences. Forgetfulness and deficiencies in judgment manifest themselves both in verbal and behavioral cues. Comprehension refers to the ability to understand what is said and is evidenced by appropriate answers. Judgment is a more complex process involving evaluation and formulation of opinions and is evidenced by incorrect or inappropriate responses, depending upon the nature of the interviewing tool being used.

Integration of facts and ideas is a higher level of thought which utilizes comprehension and judgment, possibly with contributions from memory. Failure in this area would, again, be evidenced in different ways, depending on the tool used.

Diseases.—The two most common diseases affecting mentation are stroke and cerebral arteriosclerosis. In either disease the mentation problems may be constant or intermittent. Communication with these persons is difficult but answers can be reliable in certain areas. This problem calls for astute judgment on the part of the interviewer. If the mentation problem is intermittent, the time the interviewer chooses to interview is of critical importance.

Meaning.—Deficits in mentation are not an all or nothing affair. Some persons may be aware to some degree of their deficits in one or more areas of mentation. It is also reasonable that this is a matter of great worry and concern to them, a cause for defensive and coping strategies. Denial of the problems may occur more in maximally deficient than in those minimally so. Denial, if present, requires that the interviewer use judgment in recording answers depending on whether straightforward accuracy is desired or whether the exact response to a standard stimulus is desired (Bloom & Blenkner, 1970).

Strategies.—The most useful strategy is patience to allow the older person to understand the question and to gather his thoughts and then to report his decision. While it might be possible for an interviewer to provide various types of orientation or benchmarks, utilizing where possible objective evidence like a calendar, this might accentuate the person's awareness and concern over the deficit. If an orienting statement could occur naturally, this would facilitate the interview. The more questions concern the immediate and the concrete, the easier it will be for a person with some problems in mentation to answer. Questions, as ever, must be constructed for the utmost clarity, simplicity, and brevity. Sometimes, supplying the person with relevant reference points assists their recall. "You said that you were in the hospital in the summer, and now you are at this nursing home. What happened in the fall?"

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Summary and Case Illustration

This paper is a working document; it is an attempt to suggest strategies derived from our experiences to both maximize data collection and minimize stress to older interviewees. It is, necessarily, incomplete but it will have succeeded in its purpose if it stimulates the reader to think more clearly about the problems of interviewing the ill aged and to add his experiences to these recorded here.

We have arbitrarily distinguished nine functional problems, but it is rare that only a single problem is present. With multiple problems, one must be sure that the total interviewing strategies complement one another. We would like to present a case study which demands of the interviewer consideration of several groups of strategies. This case, an actual although disguised case, challenges the ingenuity of the interviewer.

Mrs. S. was an 89-year-old widow of 30 years, who lived alone in a single dwelling which she worried about constantly. Her only sister lived out of state and was continually trying to get Mrs. S. to move. Mrs. S. knew she should move but could find no solution to her problem, since she truly needed her familiar surroundings to function independently. She was almost blind from cataracts and very fearful of becoming housebound. If a day passed that she did not get to the corner store, she would worry about ever "getting out" again. She was a person who needed freedom and space. Mrs. S. also had colitis and gall bladder disease, and this in addition to her visual loss had dulled her appetite. She had hypertension, which often affected her sense of balance, and had fallen several times. Her hearing was becoming quite poor and with her visual loss this prevented lip reading or orienting herself visually toward a speaking person. She was becoming quite isolated. She was lean, and had no orthopedic or cardiac problems, so that walking per se was not difficult, but walking somewhere was. When she walked to the store, she was so tense that her legs became lame for hours after her return home. A stranger seeing her would not be aware of this, but rather would see an angry-looking old lady, so thin that her arms and legs were like pipestems, leading with her chin, staring unseeing straight ahead, not hearing people who greeted her, walking rigidly and determinedly, asking strangers to pilot her across busy intersections.

Mrs. S. might seem to have overwhelming problems which would make interviewing extremely uncomfortable and difficult. However, by considering her problems and adapting to them, interview data can be obtained without undue stress on either Mrs. S. or the interviewer. During the initial period of rapport finding and throughout the interview, Mrs. S.'s hearing problem would be minimized by the interviewer's speaking distinctly in a low-pitched normal voice and by speaking directly to her. Extraneous "chit-chat" should be eliminated. Because of Mrs. S.'s visual problem, the other hearing strategies mentioned above are not pertinent. The interviewer should maximize whatever visual acuity is present by sitting in a good diffused light, if possible avoiding glare and reflections from Mrs. S.'s glasses. It would also help to avoid excessive movements, both personal and of objects such as notebooks. Since Mrs. S. is intelligent and independent by nature, the interviewer could ask her where she could sit to make the interview more comfortable and productive.

If the interview does not involve Mrs. S.'s moving about, her balance problem does not affect the interview, but if the interview requires that she move about she would need to move very slowly and be given time to achieve stability both before and after moving.

The pain associated with colitis and gall bladder disease is of the intermittent type and, therefore, may or may not be present at the time of interview. If pain is present, the interviewer is justified in starting the interview to see whether the client can tolerate it, or whether the interview should be rescheduled. Also, at times the pain may be due to psychological causes which may be alleviated by the social contact of the interviewer and by reassurance.

Thus, even in a complex case with multiple problems, it is possible to select suitable strategies, to minimize stress both for the client and the interviewer, and to obtain valid and reliable information.

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HONORING THE CLIENT'S RESISTANCE - Outline
from Interpersonal Process in Psychotherapy:
A Guide for Clinical Training by Edward Teyber

I. Conceptual Overview

The therapist just finished what seemed to be a productive first session with a client - the beginning of a good working relationship. The client is looking forward to the next session and has scheduled the appointment for the following week. A few days later, the client calls and cancels the appointment. It leaves the therapist puzzled and frustrated.

All clients experience positive and negative feelings when entering therapy. Clients in distress look to therapy for relief. However, the complexity of feelings involved may also cause resistance on the part of the client.

II. Both Therapists and Clients Want to Avoid Resistance

A. The Therapist's Reluctance to Address Resistance

1. The therapist is not aware of the multiple meanings and conflicted issues that therapy arouses for new clients.
2. Resistance can be used to keep the therapist in a superior position and to deny the validity of the client's own experience.
3. The therapist has a strong need for the client to like them.
4. To ward off unwanted criticism, the therapist often hesitates to invite clients to express negative reactions they have toward the therapist or being in therapy.

B. The Client's Reluctance to Address Resistance

1. Clients interpret their own resistance as being bad and project this critical attitude onto the therapist.
2. Past experiences with family members and other significant relationships give clients reason for not wanting to ask for help, not sharing painful feelings, or not risking a disclosing relationship.
3. Clients are confused by their own contradictory behavior when they see themselves resisting.

C. Steps in Identifying the Source of Resistance

1. The therapist must help clients understand why they originally needed to defend themselves and how they are continuing to do that now in therapy.
2. Therapist must validate the client's unmet need and the necessary protection this resistance once provided.
3. Therapist must differentiate his or her own response in the current relationship from the aversive ways that significant others have responded in the past.

III. Identifying and Conceptualizing Resistance

A. How Does the Therapist Know When a Client is Resisting Treatment?

1. The client misses the appointment or comes late.
2. The client needs to reschedule the appointment.
3. The client has very limited hours available for therapy.
4. The client cannot make a firm commitment to attend the next session.

B. The Therapist's Formulation of Working Hypotheses

1. What does the client's interpersonal style tend to elicit from others? For example, if the client sounds helpless and confused on the telephone, might he or she adopt a victim stance and invite others' rescuing behavior?
2. What might this particular client find threatening about being in therapy? For example, Is it incongruent with this client's perfectionistic demands to need help?
3. How will the client express resistance? For example, suppose that a therapist has observed that her depressed client feels selfish and guilty whenever she does something for herself, or whenever someone does something for her. The therapist then hypothesizes that this client may withdraw from treatment as soon as she starts to feel better, or emotionally disengage from the therapist when she realizes that the therapist genuinely cares for her.

V/F Validation® Training Institute, Inc., Naomi Feil, M.S.W., A.C.S.W., Executive Director

VALIDATION THERAPY

A New Approach to Understanding Disoriented Elderly

WHAT IS VALIDATION THERAPY?

Validation is a tested model of practice that helps old disoriented people reduce stress, enhance dignity and happiness.

Developed from 1963 to 1980 by Naomi Feil, M.S.W., A.C.S.W., Validation accepts the old person who returns to the past. Often his/her retreat is not mental illness or disease, it is survival. In old age, people can survive through hind-sight. When eyes fail, they see with the mind's eye. When hearing fails, they hear sounds from the past. They see childhood scenes when recent memory and friends die. They restore the past to relive good times and resolve the bad in this final struggle to find peace. Validation helps them win!

Validation therapy was developed to help those diagnosed with Alzheimer's and related disorders who are disoriented in the later stages of life. Older persons who are trying to "tie up loose ends" by retreating into fantasy or confusion are often brought closer to reality and security.

Using Validation Therapy both individually and in groups, we tune into the world of the elderly. Traveling back in time and space with them, we can begin to understand the underlying life themes that are being expressed. By careful listening, eye contact and touch, pacing body rhythms, the person trained can build a sense of mutual respect and trust with the elder. Most important, feelings and memories can be understood and interpreted.

Through Validation techniques we are able to enter the person's inner world. Empathy builds trust, trust gives strength, strength reduces stress, helping to restore well being and happiness.

Four Stages:

1. Malorientation
2. Time Confusion
3. Repetitive Motion
4. Vegetation

Each stage is defined in terms of emotional characteristics, physical characteristics, and feelings. This validation Workshop will include films and experimental exercises and demonstrations so that participants will learn to implement Validation with disoriented old-old individuals to help restore dignity and self-worth.

Helping Skills for Malorientation

1. Build Trust: "Who?" "What?" "Where?" "When?"
2. Re-Phrase
3. Preferred Sense
4. Polarity (How Bad Worse?) (How Often?)
5. Reminisce
6. Imagine the Opposite to find a Solution (?)

Helping Skills for Stage 2 and 3

1. Touch
2. Eye contact
3. Intimacy-expressing universal human needs and feelings
4. Mirroring
5. Ambiguity
6. Match Emotions
7. Music
8. Link Behavior to Human Need

REPORTED BENEFITS OF VALIDATION

* Decreased use of chemical and physical restraints
* Increased Staff Morale
* Increased Staff Productivity
* Decreased Staff Burn-out
* Staff stays on job; Less staff turn-over
* Residents gain dignity
* Residents gain controls and roles in Validation groups
* Families gain empathy for "Alzheimer's Victims"
* Staff and Family learn Validation Helping Methods to prevent withdrawal inward to vegetation
* Validation helps families keep relatives at home
* "Alzheimer-type" older people can remain in their own home
* Self-awareness of one's own aging
* Families and workers learn how to cope with loss to prepare for their own mentally healthy old-old age!

Videos illustrating these skills are available from the The V/F Validation Training Institute, Inc: Looking for Yesterday and The More We Get Together. To order call: (216) 561-0357 or (216) 881-0040

ASSESSMENTS

Scales to Measure Competence in Everyday Activities -- M. P. Lawton
- Physical Self-Maintenance Scale (PSMS)
- Instrumental Activities of Daily Living (IADL) Scale

Cognitive Assessments --
- Mini-Mental State Examination (MMSE J. R. Cockrell and M. F. Folstein)
- Short Portable Mental Status Questionnaire -- E. Pfeiffer

Geriatric Depression Scale (Short and Long Form) -- J. I. Sheikh and J. A. Yesavage

Social Service Initial Psychosocial Assessment and Plan -- S. Shekelle

Psychosocial Assessment -- D. R. Myers

Sample Psychosocial Assessment -- S. Luk

Sample Case Management Assessment and Care Plan -- D. Garcia

Home Health Care Case Example -- E. Stevens

"Geriatric Assessment Methods for Clinical Decisionmaking" -- NIH

Home Safety Checklist for Older Consumers -- U.S. DHHS

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VOL. 24, NO. 4, 1988

Scales to Measure Competence in Everyday Activities

M. Powell Lawton, Ph.D.,[1]

Introduction

This article deals with a very limited segment of behaviors that are among the most necessary for life preservation but the most likely to fail in the face of physical and mental disability, namely, activities of daily living. Because of the central importance of such activities in the everyday lives of older people, they are basic functions that should be included in every battery of assessment devices intended to evaluate the treatment of disabled people.

Activities of daily living (ADL) are of two types: physical activities of daily living and instrumental activities of daily living (IADL). A structure within which daily behavior may be understood will be presented before the review of measures designed to evaluate ADL and IADL. With this structure as a guide, some of the highlights of our knowledge about the most frequent ADL measures will be reviewed. Because our knowledge covers only a very limited number of such activities, the conceptual structure helps us recognize where some of the gaps in knowledge lie.

A Structure for Specifying a Taxonomy of Behavioral Competence

Figure 1 shows a schematization of a behavior hierarchy, with five gross categories of behavior arranged in order from left to right according to a hierarchy of complexity, in the sense of an increasing involvement of different systems of person and environment (from Lawton 1983). These five categories were specified in an effort to subsume all possible behaviors that are capable of being evaluated by normative standards. Within each of the five categories, a within-group hierarchy of complexity is also suggested, complexity depending more on intracategory relationships than on between-category ones. The notations within each category are illustrative only; these entries are meant to show by example the types of behaviors that might be included, and to suggest that every type of behavior may be assessed in terms of the competence with which it is performed. I have written at greater length about this conception (Lawton 1972), and about how behavioral competence is related to environment (Lawton 1982) and to perceived quality of life and psychological well-being (Lawton 1983).

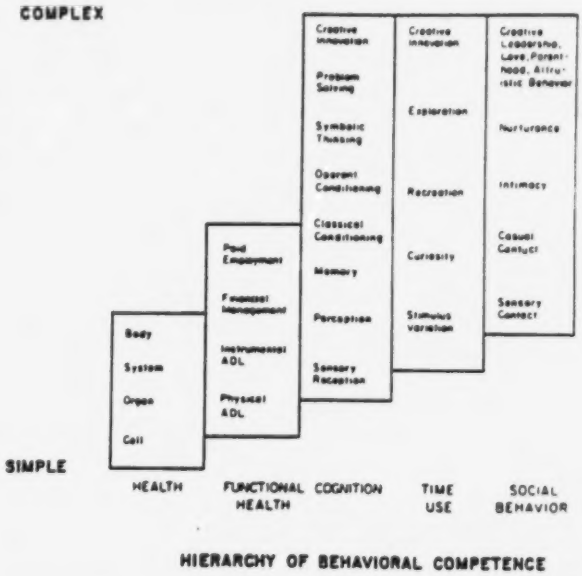

FIGURE 1. Hierarchy of behavioral competence. (Reprinted with permission from the Gerontological Society of America, copyright 1983. Lawton, M.P. Environment and other determinants of well-being in older people. *Gerontologist* 23:349–357, 1983.)

The behavioral competence domains include:

1. *Physical health*, variously indicated by physician's diagnosis, the subject's report of diagnosed conditions, laboratory tests, or days of hospitalization.
2. *Functional health*, which refers to physical self-maintenance skills (toileting, dressing, eating, bathing, ambulation, and sometimes transfer, grooming, cutting toenails, and other skills); and instrumental activities of daily living (shopping, use of transportation, cooking, housecleaning, laundry, use of telephone, taking medicine, financial management, and sometimes handyman work, heavy housecleaning, or yard work).
3. *Cognition*, that is, performance on any of a large variety of verbal or nonverbal intellectual tests.
4. *Time use*, which refers to the subject's participation in community activities, formal associations, informal diversionary activities, hobbies, or spectator activities (either live or through media).

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5. *Social behavior*, which includes all activities with others in which the focus is on the social interaction rather than on a task—normally with family, friends, neighbors, or tradespeople.

Physical Activities of Daily Living

Activities of daily living were among the first health-related behaviors to receive formal assessment. One of the earliest and still probably the most-used measure is a scale that assesses independence vs. dependence on 3-point rating scales in the areas of bathing, dressing, transfer, toileting, incontinence, and feeding (Katz et al. 1963). Lawton and Brody (1969) used a variant of the ADL that provided separately defined 5-point scales for observer ratings of bathing, dressing, toileting, eating, ambulation, and grooming (reproduced in the Instruments Section of this issue). Both of these scales, when their six items are scored dichotomously, form hierarchical scales according to Guttman criteria (Katz et al. 1970; Lawton & Brody 1969).

TABLE 1. Percentages of Population Aged 65 and Over With Activity Limitations.

Activity	Difficulty Performing Activity (%)	Receive Help With Activity (%)
Self-care[a]		
Eating	1.8	1.1
Using toilet	4.3	2.2
Dressing	6.2	4.3
Transferring	8.0	2.8
Getting outside	9.6	5.3
Bathing	9.8	6.0
Walking	18.7	4.7
One or more activities	22.7	9.6
Home management[a]		
Using telephone	4.8	3.0
Managing money	5.1	4.8
Preparing meals	7.1	6.0
Doing light housework	7.1	6.2
Shopping	11.1	10.5
Doing heavy housework	23.8	19.3
One or more activities	26.9	22.2
Work-related[b]		
Walking up 10 steps	18.9	
Standing 2 hours	27.8	
Sitting 2 hours	10.1	
Stooping, crouching, kneeling	33.9	
Reaching up over head	13.6	
Reaching out to shake hands	1.9	
Grasping with fingers	9.1	
Lifting or carrying 25 pounds	28.0	
Lifting or carrying 10 pounds	9.2	

[a] From National Center for Health Statistics (1987*b*), National Health Interview Survey Supplement on Aging, Tables 1, 2, 3, 4, 5, 6, 7, and 8.
[b] Percentages for people aged 65 to 74 who have worked since age 45. From National Center for Health Statistics (1987*a*), National Health Interview Survey Supplement on Aging, Table 1.

One of the comprehensive multiple-factor scales, the Older American Research and Service Center (OARS) instrument (Duke University 1978) used similar behaviors but adapted the question format in such a way that meaningful responses could be yielded by either an observer or the subject in a self-rating. That is, each item was asked in the form, "Do you do it without help, with some help, or don't you do it at all?"

Some of these items have been used in the Supplement on Aging of the National Health Interview Survey (NHIS) performed by the National Center for Health Statistics (1987*a*, 1987*b*). These items are asked in dichotomous fashion in two ways, first in terms of "Do you have difficulty. . . ?" and, second, "Do you receive any help with . . . ?" The top section of Table 1 shows the differing distributions and prevalences of limitations in these activities as ascertained by the two methods. Since the sample used was a large, carefully chosen, nationally representative sample of people over 65, these figures may be accepted as the best available estimates of these disabilities. However, an overall scoring system is not available for the set of items in the NHIS form.

Instrumental Activities of Daily Living

As suggested in Figure 1, the IADL items are more complex, in the sense of requiring greater skill, independence, judgment, and combinations of tasks. Lawton and Brody's (1969) original IADL scale consists of eight multiple-point ratings, with definitions of adequate performance requiring the judgment of a rater, with regard to the following items: financial management, shopping, transportation use, telephoning, medication use, housekeeping, cooking, and laundry (reproduced in the Instruments Section of this issue). These items scaled hierarchically for women when each was dichotomized, but males could not be included in the same scoring system because of the gender-specific quality of some activities asked about in the "Do you do" form.

The OARS instrument also adapted these items and phrased the questions in terms of "Can (you/he/she) perform the task without any help, with some help, or can't (you/he/she) do it at all?" This "can" wording allows some discretion in accounting for such reasons for nonperformance of a task as custom, gender role allocation, or preference, although the error introduced by rating the

individual's potential rather than actual behavior is unknown.

The OARS in typical use requires the person administering the instrument or an independent rater to complete the 6-point rating shown in Table 2 on the basis of the subject's responses to all the ADL and IADL items. Later research on the OARS (Fillenbaum 1985) used large-sample OARS data in item-level psychometric analyses. The aim of these analyses was to provide shortened measures, the result being a 5-item Guttman IADL scale containing housework, transportation, shopping, meal preparation, and financial management.

TABLE 2. Performance Rating Scale for Activities of Daily Living on the Older American Research and Service Center (OARS) Instrument.

1. Performs all independent instrumental and physical functions with ease and without assistance.
2. Can perform all the usual instrumental and physical activities but at times this becomes a strain for the person and he would welcome intermittent assistance with some of these.
3. Can perform the usual instrumental and physical activities around his own home under usual circumstances but requires assistance when additional or extraordinary demands are made such as for long distance travel, major shopping trips, large financial transactions, or during a crisis situation.
4. Regularly requires help with certain activities (such as food shopping) but can get through any single day without help from anyone.
5. Needs help each day but not necessarily throughout the day or night with some of the instrumental or physical activities of daily living.
6. Needs help throughout the day and/or night to carry out the instrumental and physical activities of daily living.

Another omnibus assessment package, the Philadelphia Geriatric Center Multilevel Assessment Instrument (MAI; Lawton et al. 1982) used the ADL and IADL in the OARS format ("does" wording for ADL and "can" wording for IADL) and derived cumulative scores based on all 15 items, as shown in Table 3, for several nonrepresentative samples ordered in terms of general competence. (Versions of the ADL and IADL scales as they appear in the MAI are reproduced in the Instruments Section of this issue.)

The Comprehensive Assessment and Referral Evaluation (CARE; Golden et al. 1984) is a structured interview that yields a number of "homogeneous item scales," including one named "activity limitation," which contains 39 items indexing problems, troubles, and difficulties with both physical and instrumental activities. In addition to having a large number of items, the number of questions required to get to some of the scorable responses extends the data-gathering time considerably beyond that of the briefer scales described above.

The Self-Evaluation of Life Function Scale (SELF; Linn & Linn 1984) contains a single 15-item factor-derived scale that includes not only ADL and IADL items but also two health behavior items (days in bed and days in hospital).

TABLE 3. Psychometric Characteristics of MAI ADL Scales.

Measure	No. of Items	Alpha	Retest *r*	Correlations With Interviewer Rating	Correlations With Administrator Rating
Physical Self-Maintenance (ADL)	7	.83	.56	.69	.52
Instrumental Activities (IADL)	9	.91	.73	.91	.45
ADL plus IADL	16	.93	.76	.87	.68

MAI Means (± SD) on ADL for Subject Groups of Varying Competence

	Highest Competence				Minimal Competence			
	Community Residents (*n* = 253)		Public Housing (*n* = 173)		In-Home Services (*n* = 99)		Institutional Waiting List (*n* = 65)	
Measure	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Physical Self-Maintenance (ADL)	20.61	(1.18)	20.77	(0.64)	19.26	(2.49)	18.51	(2.81)
Instrumental Activities (IADL)	24.51	(3.66)	25.15	(2.72)	19.86	(3.98)	18.15	(4.91)
ADL plus IADL	45.12	(4.57)	45.92	(3.07)	39.12	(6.03)	36.66	(6.97)

NOTE: ADL = activities of daily living; IADL = instrumental activities of daily living; MAI = Multilevel Assessment Instrument.

The NHIS also used six IADL tasks as indicated in the second panel of Table 1, where the percentages indicate the prevalences of people reporting difficulty and people receiving help with the activities.

The only attempt to construct a single hierarchical scale of both ADL and IADL items was reported by Spector and Katz (1987), who found that independence vs. dependence in shopping, transportation, bathing, dressing, transferring, and eating formed a very tight Guttman scale. This research confirms the hypothesis that the IADL behaviors are hierarchically more complex than ADLs.

The consensus among investigators in choosing the behaviors to compose the ADL and IADL domains is very high. Of course, many other behaviors could be candidates for such scaling. For example, the third panel of Table 1 shows a group of work-related behaviors that are clearly more physically demanding than many of the ADL and IADL tasks. For people potentially in the work force, such behaviors might constitute a more relevant set of criterion activities than the less complex ADLs.

Similarly, for assessing the results of rehabilitative activity, the ADL/IADL are far too gross. "Range of motion" inventories that index specific limb, muscle, or molecular functional behaviors may be more appropriate for this purpose. The Kenney Self-Care Evaluation (Schoening et al. 1965) elaborates the ADL into some more finely differentiated features. However, most really detailed inventories have typically not been subjected to psychometric analysis in the depth done for ADL.

Recommendations for Scales

If the purpose is primarily one of being able to compare a group of subjects with normals, the NHIS questions and format are clearly preferable. Only the NHIS data are available on a nationally representative sample of all people 65 and over.

However, the usual need is for a scaled instrument with sensitivity and specificity and other known psychometric characteristics, criteria which the NHIS items do not meet. A number of researchers in the field have emphasized the hierarchical arrangement of items as a criterion for unidimensionality and low redundancy. That is, the Guttman scalogram analysis technique allows the arrangement of items in a specified order of difficulty, with the property that items of differing difficulty will be responded to in the same order of affirmation by almost everyone who answers the set of questions. The Katz ADL, the Lawton and Brody ADL and IADL, the Fillenbaum IADL, and the ADL-IADL composite of Spector and Katz have these properties. However, the loss of redundancy is problematic for situations where sensitivity is desirable and the error rate high. The range of competence across which these measures discriminate builds in opportunities for error in either self-ratings or observer ratings. In addition, every item is scored as a dichotomy, forcing the loss of the discriminating ability of the multiple scale points actually used in the ratings. Therefore, for testing psychopharmacological treatment effects, the versions of the scales that use additive ratings appear preferable.

The other considerations in making-a choice between instruments are diverse. One issue is the length of time required for an observer or a self-rater to complete the scale. All the scales named do well in this respect, an average of 5 minutes or even less being sufficient time for most. All the scales also do well in representing the consensually chosen best functions. Interestingly enough, incontinence does not do well as an item in either scalogram or factor-analytic approaches to scaling and probably needs to be considered separately from toileting, in the sense of being able to get to and manage the operations of using the toilet.

The Katz and the Lawton and Brody ADL scales lend themselves well to item summation to produce a total score. However, neither has been reported in this format and their use in relation to known scores of other subjects requires the items to be scored dichotomously, yielding total scores with a range of only 0 to 6.

There is thus some gain in moving toward the revisions of the basic ADL introduced by the OARS group and repeated in the MAI. These instruments assess responses on 3-point scales (activity performed without help, with some help, or not performed at all) that extend the range of the total ADL score from 7 to 21. Standardization information on the 7-item ADL does not seem to be available for the OARS, but is available for the MAI (Lawton et al. 1982, and in Table 3). Since the OARS standardization samples are much larger, such norms, if eventually published, would be the best guides by far for comparisons of individual and group data. Pending such publication, the means and standard deviations for several nonrepresentative subject groups on the MAI form of the two scales may be used as tentative norms (*see* Table 3).

A number of scales have been devised that combine the ADL and IADL domains into a single scale, including the Spector and Katz (1987) instrument, the CARE (Golden et al. 1984), and the functional health scale of the MAI. Recent analysis of the National Center for Health Statistics Long Term Care Survey (Macken 1986) and some results from large-scale demonstration research (the "Channeling Project"; Kemper et al. 1986) have made clear that substantially different patterns of service delivery and social support occur as a function of whether an individual is impaired only in instrumental tasks or in both instrumental and physical maintenance tasks. Therefore it

seems extremely desirable to measure them separately and combine them later, if necessary.

The source of the ADL ratings constitutes another issue relevant to the choice of measures. Most of the earlier measures of both physical and instrumental activities required ratings from observers, since many of them depend on the ability to discriminate among scale points defined in relatively complex terms. Very often, the influences of observer type were unexplored, but the ability of even lowest level direct-care personnel to agree on such ratings was demonstrated for most of the scales. Such scales are not easily comprehended by impaired subjects themselves, however. The introduction of the 3-point form in the OARS was a step that made possible the use of such items in self-responding form.

One concludes, therefore, that if staff are available who can be trained to use the longer, more explicitly defined scales, such as those represented in the Lawton and Brody ADL, the sensitivity of the ratings will probably be greatest. If self-ratings are required, or a scale that can be rated by either subject or observer, then the OARS form will be preferable.

Inadequate information is available at present on types of bias or error that are introduced as a function of whether the rater is the subject or a professional observer, a direct-care observer, or a family member. Differences have been shown to occur among these groups, and the differences appear to be partly related to which functions are being rated (Edwards & Danziger 1982; Magaziner et al. 1987; Rubenstein et al. 1984). Although relevant findings in this area are too spotty to warrant summarization at this point, it is clear that rater error may be systematic and that particular caution must be exercised when the procedure requires the mixing of ratings from different sources.

A longer review of similar scales, as well as reproductions of a number of the actual scales, may be found in McDowell and Newell (1987, Chapter 3).

In summary, the original Katz ADL is probably the most widely used, and one of the easiest-to-use, measures of physical ADL, if modest discriminating power is adequate. The Lawton and Brody ADL adds a greater range of scores and therefore may have greater sensitivity, although this has not been demonstrated. The 3-point scale versions of ADL that are used in the OARS and the MAI have the advantage of having more psychometric information available. The only form of IADL with adequate psychometric qualities is the OARS version, which suffers from the present lack of full psychometric study and norms. The MAI version of IADL is present in the OARS form, and extensive psychometric information, plus means and standard deviations on several diverse but not representative samples, are available.

Since activities of daily living are basic to understanding the functioning of older people, and since no combination of ADL and IADL measures would consume more than 5 to 7 minutes during an assessment procedure, inclusion of these measures in a battery for clinical trials research seems almost obligatory.

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Physical Self-Maintenance Scale (PSMS)[1]

Self-Rated Version

Incorporated in the Philadelphia Geriatric Center

Multilevel Assessment Instrument (MAI)

For information on this instrument, see the review article by Lawton, this issue. (This instrument is reprinted with permission of the Gerontological Society of America, ©1982, from Lawton et al.: A research and service-oriented Multilevel Assessment Instrument, *J. Gerontol.* 37:91–99, 1982.)

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Address inquiries regarding this scale to:

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[1]Adapted by Elaine M. Brody and M. Powell Lawton from the Langley-Porter Physical Self-Maintenance Scale.

Source: "Assessment in Diagnosis and Treatment of Geropsychiatric Patients." Psychopharmacology Bulletin. National Institute of Mental Health, Vol.24, No.4, 1988., pgs. 796-797.

Physical Self-Maintenance Scale (PSMS)

Self-Rated Version Extracted From the Multilevel Assessment Instrument (MAI)

1. Do you eat:

   without any help, 3

   with some help (cutting food, identifying for blind, etc.), or 2

   does someone feed you? 1

2. Do you dress and undress yourself:

   without any help (pick out clothes, dress and undress yourself), 3

   with some help (dressing *or* undressing), or 2

   does someone dress *and* undress you? 1

3. Do you take care of your own appearance, things like combing your hair (FOR MEN: and shaving):

   without help, 3

   with some help, or 2

   does someone do all this type thing for you? 1

4. Do you get around your (house/apartment/room):

   without help of any kind (except for a cane), 3

   with some help (from a person or using a walker, crutches, chair), or 2

   don't you get around your home at all unless someone moves you? 1

PSMS-Self *(continued)*

5. Do you get in and out of bed:

without any help or aid,	3
only with some help (from a person or device), or	2
don't you get in and out of bed unless someone lifts you?	1

6. Do you bathe—that is, take a bath, shower, or sponge bath:

without any help,	3
with some help (from a person or device), or	2
only when someone bathes you (lifts in and out or bathes)?	1

7a. Do you ever have trouble getting to the bathroom on time?

Yes	1
No	2

7b. About how often do you wet or soil yourself during the day or night?

Never	4
Less than once a week	3
Once or twice a week	2
Three times a week or more	1

Instrumental Activities of Daily Living (IADL) Scale

Self-Rated Version

Incorporated in the Philadelphia Geriatric Center

Multilevel Assessment Instrument (MAI)

For information on this instrument, see the review article by Lawton, this issue. (This instrument is reprinted with permission of the Gerontological Society of America, ©1982, from Lawton et al.: A research and service-oriented Multilevel Assessment Instrument, *J. Gerontol.* 37:91–99, 1982.)

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Lawton, M.P., and Brody, E.M. Assessment of older people: Self-maintaining and instrumental activities of daily living. *Gerontologist* 9:179–186, 1969.

Lawton, M.P.; Moss, M.; Fulcomer, M.; and Kleban, M.H. A research and service-oriented Multilevel Assessment Instrument. *J. Gerontol.* 37:91–99, 1982.

Address inquiries regarding this scale to:

M. Powell Lawton, Ph.D.
Philadelphia Geriatric Center
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Philadelphia, PA 19141

Source: "Assessment in Diagnosis and Treatment of Geropsychiatric Patients." Psychopharmacology Bulletin. National Institute of Mental Health, Vol. 24, No. 4, 1988, pgs. 789-791.

Instrumental Activities of Daily Living (IADL)

Self-Rated Version Extracted From the Multilevel Assessment Instrument (MAI)

1. Can you use the telephone:

without help,	3
with some help, or	2
are you completely unable to use the telephone?	1

2. Can you get to places out of walking distance:

without help,	3
with some help, or	2
are you completely unable to travel unless special arrangements are made?	1

3. Can you go shopping for groceries:

without help,	3
with some help, or	2
are you completely unable to do any shopping?	1

4. Can you prepare your own meals:

without help,	3
with some help, or	2
are you completely unable to prepare any meals?	1

5. Can you do your own housework:

without help,	3
with some help, or	2
are you completely unable to do any housework?	1

Mini-Mental State Examination (MMSE)

J. Robert Cockrell, M.D., and Marshal F. Folstein, M.D.[1]

General

The Mini-Mental State Examination (MMSE; Folstein et al. 1975) is a widely used clinical instrument for the preliminary screening, diagnosis, and serial assessment of psychogeriatric patients, providing a very brief but formal and relatively thorough measure of cognition. It does not measure other mental phenomena, such as mood, perception, and the form and content of thought, and is therefore not a substitute for a full mental status examination. It is also not a substitute for extensive neuropsychological evaluation, but may well indicate when and what kind of such evaluation is appropriate. It is most suitable for detecting the cognitive deficits seen in syndromes of dementia and delirium and for measuring these cognitive changes over time, reflecting its initial development on a psychogeriatric inpatient unit.

The MMSE has equal utility as a reliable, valid instrument in psychogeriatric research. It can screen potential subjects for the presence of cognitive impairment. It can be an operational tool in establishing diagnosis. It can serve as an inclusion or exclusion criterion for entrance into clinical trials or field studies (as a measure, for example, of a dementia threshold). And, through serial administration, it can monitor cognitive changes during drug trials and other interventions.

Administration and Scoring

The MMSE is divided into two sections, contains 11 tasks of cognition, and requires 5 to 10 minutes to administer. The test is not timed. Its brevity makes it easily administered to large numbers of subjects and to subjects who are able to cooperate only for short periods. Its simplicity is such that it can be properly administered by clinical or lay personnel with little training. It is readily accepted by both subjects and personnel.

Summing the points assigned to each successfully completed task produces a numerical score of 0 to 30, with 30 a perfect score. The first section requires vocal responses only and covers orientation, memory, and attention; the maximum score is 21. The second section tests ability to name, follow verbal and written commands, write a sentence spontaneously, and copy two overlapping pentagons; the maximum score is 9. Spencer and Folstein (1985) provide precise instructions for administering and scoring the examination, including consideration of special circumstances. Normative data have been collected for a number of samples, including three Eastern Baltimore catchment areas which were surveyed under the auspices of the National Institute of Mental Health Epidemiologic Catchment Area Program (Folstein et al. 1985).

Reliability

The reliability of the MMSE has been demonstrated in both psychiatric and neurologic populations (Folstein et al. 1975). Test-retest reliability over a 24-hour period in these samples is at least .89, whereas interrater reliability using two different examiners with administrations 24 hours apart is at least .82. In the same study, when clinically stable groups of elderly depressed and demented subjects were tested an average of 28 days apart, the resulting correlation was .98.

Validity

The validity of the MMSE is demonstrated by a predicted, significant, positive correlation between elderly subjects' MMSE scores and their scores on both the verbal and performance sections of the Wechsler Adult Intelligence Scale (Folstein et al. 1975). Further evidence of validity is its correlation with findings from computerized tomography of the brain (Tsai & Tsuang 1979) and from electroencephalography (Tune & Folstein 1986).

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This instrument is reprinted with permission of Pergamon Press, Inc., ©1975, from Folstein et al.: 'Mini-Mental State': A practical method for grading the cognitive state of patients for the clinician, *J. Psychiatr. Res.* 12:188–189, 1975.

Several studies demonstrate the sensitivity and specificity of the MMSE in various populations. Folstein et al. (1975) reported that of 63 surveyed elderly residents of a retirement apartment complex in Westchester, New York (assumed, without examination, to be healthy), all scored at least 24 points on the MMSE. DePaulo and Folstein (1978) reported that of 26 neurological patients with spinal cord or peripheral nerve injury or neuromuscular disorder, all scored at least 24 points on the test. Anthony et al. (1982) assessed its sensitivity and specificity on a general medical ward: with a psychiatrist's standardized clinical diagnosis as the criterion, the MMSE was 87 percent sensitive and 82 percent specific in detecting dementia and delirium when scores of 23 or below were considered indicators of these conditions. The same study demonstrated that performance on the MMSE can be influenced by educational level: the false-positive rate was 39 percent, and all false positives had fewer than 9 years of education. By contrast, the false-negative rate was 5 percent. By using selected items of the MMSE, Klein et al. (1985) demonstrated sensitivity above 90 percent and specificity above 80 percent in identifying dementia in hospitalized patients over age 40.

Thus, although the MMSE alone is, of course, unable to yield an accurate diagnosis, the data on its sensitivity and specificity demonstrate its utility as a screening instrument: a score of 23 points or less by an individual with more than 8 years of education may be considered evidence of cognitive impairment and grounds for further diagnostic evaluation as a potential research subject. While the score of 23 has been established as a threshold for indication of cognitive impairment and is used in this way as an inclusion or exclusion criterion in drug trials, other scores can be chosen as cut-off points for including or excluding subjects in various protocols requiring a specified level of impairment or no impairment at all.

Serial administration of the MMSE has been employed to monitor cognition changes over the course of various studies. In Alzheimer's disease subjects receiving progressively higher doses of neuroleptic medication, Steele et al. (1986) demonstrated that higher neuroleptic doses were associated with diminution of MMSE score and with the development of detectable serum anticholinergic levels. Tune and Folstein (1986) noted a positive association between increase of MMSE score and clearing of postoperative delirium. Since 1984 the MMSE has been used to document progressive decline in the cognitive status of subjects followed longitudinally in the multicenter National Institute on Aging Alzheimer's Disease Research Centers.

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Folstein, M.; Anthony, J.C.; Parhad, I.; Duffy, B.; and Gruenberg, E.M. The meaning of cognitive impairment in the elderly. *J. Am. Geriatr. Soc.* 33:228–235, 1985.

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Steele, C.; Lucas, M.J.; and Tune, L. Haloperidol versus thioridazine in the treatment of behavioral symptoms in senile dementia of the Alzheimer's type: Preliminary findings. *J. Clin. Psychiatry* 47:310–312, 1986.

Tsai, L., and Tsuang, M.T. The Mini-Mental State test and computerized tomography. *Am. J. Psychiatry* 136(4A):436–438, 1979.

Tune, L., and Folstein, M.F. Post-operative delirium. *Adv. Psychosom. Med.* 15:51–68, 1986.

Address inquiries regarding this test to:

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Mini-Mental State Examination (MMSE)

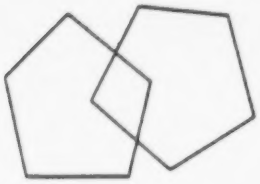
			Score	Points
Orientation				
1.	What is the	Year?	___	1
		Season?	___	1
		Date?	___	1
		Day?	___	1
		Month?	___	1
2.	Where are we?	State?	___	1
		County?	___	1
		Town or city?	___	1
		Hospital?	___	1
		Floor?	___	1
Registration				
3.	Name three objects, taking one second to say each. Then ask the patient all three after you have said them. Give one point for each correct answer. Repeat the answers until the patient learns all three.		___	3
Attention and calculation				
4.	Serial sevens. Give one point for each correct answer. Stop after five answers. *Alternate:* Spell WORLD backwards.		___	5
Recall				
5.	Ask for names of three objects learned in question 3. Give one point for each correct answer.		___	3
Language				
6.	Point to a pencil and a watch. Have the patient name them as you point.		___	2
7.	Have the patient repeat "No ifs, ands, or buts."		___	1
8.	Have the patient follow a three-stage command. "Take the paper in your right hand. Fold the paper in half. Put the paper on the floor."		___	3
9.	Have the patient read and obey the following: "CLOSE YOUR EYES." (Write it in large letters.)		___	1

MMSE *(continued)*

10. Have the patient write a sentence of his or her own choice. (The sentence should contain a subject and a verb and should make sense. Ignore spelling errors when scoring.) ___ 1

11. Have the patient copy the figure below. (Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle.) ___ 1

_____ = Total 30



Source: "Assessment in Diagnosis and Treatment of Geropsychiatric Patients." Psychopharmacology Bulletin. National Institute of Mental Health, Vol.24, No.4, 1988.

Short Portable Mental Status Questionnaire

1. What is the date today (month/day/year)? All three correct to score.
2. What day of the week is it?
3. What is the name of this place? Any correct description.
4. What is your telephone number? If no telephone, what is your street address?
5. How old are you?
6. When were you born (month/day/year)? All three correct to score.
7. Who is the President of the United States now?
8. Who was the President just before him?
9. What was your mother's maiden name?
10. Subtract three from twenty and keep subtracting three from each new number all the way down. Whole series needed to score.

Error score (out of 10): Add one if educated beyond high school; subtract one if black; subtract one if not educated beyond grade school.

Scoring: 0–2 errors: intact intellectual function
3–4 errors: mild intellectual impairment
5–7 errors: moderate intellectual impairment
8–10 errors: severe intellectual impairment

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. Journal of the American Geriatric Society, 23:433-441.

Geriatric Depression Scale (Short Form)

Choose the Best Answer for How You Felt Over the Past Week

1. Are you basically satisfied with your life? ..... yes / no
2. Have you dropped many of your activities and interests? ..... yes / no
3. Do you feel that your life is empty? ..... yes / no
4. Do you often get bored? ..... yes / no
5. Are you in good spirits most of the time? ..... yes / no
6. Are you afraid that something bad is going to happen to you? ..... yes / no
7. Do you feel happy most of the time? ..... yes / no
8. Do you often feel helpless? ..... yes / no
9. Do you prefer to stay at home, rather than going out and doing new things? ..... yes / no
10. Do you feel you have more problems with memory than most? ..... yes / no
11. Do you think it is wonderful to be alive now? ..... yes / no
12. Do you feel pretty worthless the way you are now? ..... yes / no
13. Do you feel full of energy? ..... yes / no
14. Do you feel that your situation is hopeless? ... yes / no
15. Do you think that most people are better off than you are? ..... yes / no

The following answers count one point; scores > 5 indicate probable depression:

1. NO	6. YES	11. NO
2. YES	7. NO	12. YES
3. YES	8. YES	13. NO
4. YES	9. YES	14. YES
5. NO	10. YES	15. YES

Sheikh, J.I. and Yesavage, J.A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. In: T.L. Brink (Ed.), Clinical gerontology: A guide to assessment and intervention, New York: Haworth Press, 165-173.

GERIATRIC DEPRESSION SCALE
(Long Form)

1. Are you basically satisfied with your life? N
2. Have you dropped many of your activities and interests? Y
3. Do you feel that your life is empty? Y
4. Do you often get bored? Y
5. Are you hopeful about the future? N
6. Are you bothered by thoughts that you just cannot get out of your head? Y
7. Are you in good spirits most of the time? N
8. Are you afraid that something bad is going to happen to you? Y
9. Do you feel happy most of the time? N
10. Do you often feel helpless? Y
11. Do you often get restless and fidgety? Y
12. Do you prefer to stay home at night, rather than go out and do new things? Y
13. Do you frequently worry about the future? Y
14. Do you feel that you have problems with memory than most? Y
15. Do you think it is wonderful to be alive now? N
16. Do you often feel downhearted and blue? Y
17. Do you feel pretty worthless the way you are now? Y
18. Do you worry a lot about the past? Y
19. Do you find life very exciting? N
20. Is it hard for you to get started on new projects? Y
21. Do you feel full of energy? N
22. Do you feel that your situation is hopeless? Y
23. Do you think that most people are better off than you are? Y
24. Do you frequently get upset over little things? Y
25. Do you frequently feel like crying? Y
26. Do you have trouble concentrating? Y
27. Do you enjoy getting up in the morning? N
28. Do you prefer to avoid social gatherings? Y
29. Is it easy for you to make decisions? N
30. Is your mind as clear as it used to be? N

Administration

These items may be administered in oral or written format. If the latter is used, it is important that the answer sheet have printed YES/NO after each question, and the subject is instructed to circle the better response. If administered orally, the examiner may have to repeat the question in order to get a response that is more clearly a yes or no. The GDS loses validity as dementia increases Translations are available in Spanish, French and German. The GDS seems to work well with other age groups.

Scoring

Count 1 point for each depressive answer. 0-10 = normal: 11-20 = mild depression: 21-30 = mnoiderate or severe depression.

Reference: Brink TL, Vesavage, JA, Lum O. Hearsema P, Adey M & Rose TL: Screening Tests for Geriatric Depression. Clinical Gerontologist, Fall 1982, (v.1 #1) pp.37-43.

Developed and Submitted by Susan Shekelle, M.S.W.

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SOCIAL SERVICE INITIAL
PSYCHOSOCIAL ASSESSMENT & PLAN

NAME OF PATIENT: DATE OF INTERVIEW:

INTRO & REASON FOR CLINIC VISIT
- Description, physical appearance
- Accompanied by
- Information obtained from
- Referred by
- Came to GMA at this time
- Major Concerns
- Priority

Physical Health Status
- Recent medical care
- Discuss pertinent medical problems, medications, sight and hearing, smoking, alcohol and drug

Cognitive Status
- History of onset, course, and prior problems
- Current problems/symptoms, emotional changes
- Medications
- Presentation during interview
- Family history
- Folstein results
- Measures of Intellectual Function

Emotional Status
- History of problems/medication/treatment
- Family history of depression/medication/treatment
- Patient's affect, demeanor
- Geriatric Depression Scale
- SIG E CAPS
- Current Status

Psychiatric history

Functional status
- ADL's
- IADL's
- Current living situation
- Caregiver information

SOCIAL INFORMATION AND BACKGROUND

Born
Siblings
Parents
Lived - childhood, adolescence, adult life
Education
Marital history
Children
Other significant persons
Occupation of patient/spouse
Hobbies, avocation, interests, religious/church involvement
Retirement/Activity since retirement
Financial situation
Advance directives, medical and legal

ASSESSMENT, SERVICES AND PLAN

Assessment of patient
Assessment of family
- Caregiver burden

Adjustment of patient to illness
Adjustment of family to illness

Information to be provided
- Description, natural history, prognosis, care needs
- Information re supportive services, groups, organizations, alternative living situations, legal issues such as living wills, durable power of attorney, wills, guardianship, etc. financial issues such as eligibility for services
- Counseling re management of behavior problems, emotional problems
- Supportive counseling

Written information provided

Plans for, or assessment of need for, future intervention

Source: Susan Shekelle, M.S.W.

Source: **Dennis R. Myers, Ph.D.**
Assistant Director, Institute for Gerontological Studies
Baylor University

PSYCHOSOCIAL ASSESSMENT

I. IDENTIFYING INFORMATION:

Full name, nickname, preferred first name, gender, ethnicity, age, complete birthday, birthplace, present address and phone number. If the person lives alone, obtain the name and phone number of a nearby neighbor or friend.

II. PRESENTING ISSUES:

What are the factors which seem to explain why the older person and/or family/collateral has contacted the center? What seems to have precipitated the request for help? For what does the older person and/or the family/collateral seem to be asking? Are other service providers involved in resolution of the presenting issues? What is the older person and/or family/collateral doing to deal with these issues?

III. SUPPORT SYSTEM INFORMATION:

A. Marital information: What is the present marital status, full name of the spouse and date of marriage to present spouse. If the person is separated, divorced or the spouse is deceased, give the date of this occurrence. Obtain the names of prior marital partners and the date of death or divorce.

B. Children, grandchildren and great-grandchildren: What are the names, ages, gender, marital status and location of the older person's children, grandchildren and great-grandchildren? If any are deceased, obtain the date and cause of death. What is the amount and quality of interaction between the older person and these offsprings? Which persons seem to be a source of significant support to the older person?

C. Parents: Ask for the full name and age of the father and mother, if living. If not living, obtain the date of death and the cause. Ask about the name of the older person's relationship with his/her parent and if the older person is/was involved as a caregiver for them.

D. Siblings and Other Kin: Obtain names, gender, ages, location, and, if deceased, the date and cause of death of the older person's sibling? How frequently does the person contact the sibling? How are they a resource to one another? What other kin are of significance to the older person? What are their names and location?

E. Friends: Who does the older person depend on in case of an emergency? Who do they talk with whenever they feel like it? Who are the three closest persons in their life and how are they important?

F. Current Household: What are the names, gender, age and relationship of the persons who live with the older person?

G. Social Participation: To what organization does the older person belong? (i.e., church, clubs, senior center, AARP). How actively does the older person participate in these programs?

IV. EDUCATIONAL AND EMPLOYMENT INFORMATION:

What is the older person's educational level in terms of years of education? When did he/she leave? Does the older person have a degree? What is the person's primary occupation or profession? What other job skills does he/she have? During the last ten years of employment, where did the person work? What was the age of the person at retirement and when did this occur? Did he/she retire voluntarily? How satisfied is he/she now? What are his/her plans for future employment?

V. MILITARY AND LEGAL INFORMATION:

Was the person in the military? What branch and how many years of service were provided? What type of discharge was received? Does the person use services of V.A. Medical Center? If so, what services are received?

Has the person ever been arrested or in prison? Does the person have a current will? Does the person have a guardian or conservator?

VI. MEDICAL INFORMATION:

What is the name of the physician(s) who the person sees now or saw within the past two years? How does the person rate their general health: excellent, good, fair, or poor? What medications does he/she take? When were they prescribed? What is the dosage schedule? What physician prescribed the medication? Did he/she have any serious illness while growing up? Does he/she have any illnesses now? Does he/she recall having the flu during the epidemic of 1918-1919? What illnesses seem to run in his/her family? Does he/she have any allergies? Is he/she allergic to any medications?

Does he/she have difficulty sleeping, eating, getting around, remembering or falling? Does he/she have any recurring physical symptoms that trouble you? Does he/she or anyone in their family have Senile Dementia? Does he/she ever wonder about seeing or hearing things that are not real? Does he/she have any problems with his/her eyes or with his/her hearing? How does he/she deal with

anger? Has the person received any psychiatric care in the past five years? If so, where did he/she receive the help? Do you consider any of the following to be a serious personal problem: eating, overdrinking, smoking, or underactivity?

Do you exercise regularly? What kind of exercise do you do? How often? Who loved you the most as a child? What are the two or three most traumatic events in your life that stand out in your mind? What are two or three events that stand out in your memory as being the happiest or satisfying?

VII. ACTIVITIES:

Note: The purpose of this section is to assess the person's ability to independently carry out the activities necessary for survival.

Ask the person to describe a typical day in his/her life. Beginning when they arise in the morning and ending when they go to bed. Probe for enough detail to assess how independently the person can handle the demands of day to day existence.

You should obtain information on how ir.dependently the person is able to do the following. If the person requires assistance to accomplish the activity, identify who assists the person.

a. Prepare and purchase meals
b. Take medication
c. Dressing and clothing care
d. Home maintenance
e. Money management
f. Exercise judgment in emergencies
g. Obtain transportation resources
h. Obtain adequate economic resources

Note: You may decide to administer the in-home behavior care checklist and summarize the findings in this section.

VIII. LEISURE ASSESSMENT:

What does the person do for fun? What are his/her hobbies? How does the person relax?

IX. ASSESSMENT:

For what does the person seem to be asking? How reliable do you consider the data you received from the older person and/or other informants? Identify the names of informants who provided the information you obtained. What is your overall assessment of the older persons health, support system, emotional/mental health and survival skills? What, in your opinion, are the strengths and needs of this person? Be sure to identify the needs as specifically as possible.

X. RECOMMENDATION:

What do you recommend for the person to meet the needs you have identified?

XI. CARE PLAN

Submitted by Susanna Luk, M.S.

PSYCHOSOCIAL ASSESSMENT

I. IDENTIFYING INFORMATION

Mrs. C is a 79 year old white female. She was born on October 20, 1913 in MacGregor, Texas. She prefers to be called *****, a beloved nickname given to her by her husband. Presently, she lives in her own home at 1756 Planters Drive in Waco, Texas (953-8699). Her granddaughter, Anna Smith, and her two great granddaughters live with her.

II. PRESENTING ISSUES

Mrs. C recently developed a vision impairing condition called macular degeneration. Although she has other physical conditions, her main request for help pertains to aid in adjusting to her loss of vision. She wants to obtain resources to enable her to read again.

Mrs. C has received services from the Texas Commission for the Blind. Her counselor is Karen Bender. The commission has provided the client with vision tests and some special eye glasses. However, those glasses are not of any use to her because they are bifocals which impede her vision more than help it. Mrs. C wants to return the glasses and hopes to get other devices to help her. She has also been exposed to vision enhancing devices by Jane Henderson, who also has the condition. She is hoping to obtain a close circuit projection device that will enable her to read; however, this device costs approximately $3,500 and she cannot afford it. Sources of funding for this machine needs to be investigated. Meanwhile, her family is with her to help with reading, transportation, household chores and such.

III. SUPPORT SYSTEM INFORMATION

Mrs. C is a widow and has been for eight years. Her husband's name was ****** . He spent thirty years in the army and was sent overseas on duty during the Korean War. He died of cancer in 1984.

The client has two children. A 54 year old daughter, Sandra Danson, who lives in Huntington, Texas and a 50 year old son, Allen C., who lives in Lockhorn, Texas. Mrs. C also has five grandchildren and five great grandchildrer:. She said that she keeps in touch with all of them except for one grandson.

He granddaughter, Anna, and her two daughters have moved in with the client. They help her with paper work, financial matters, cooking and cleaning, provides transportation, and are a great source of emotional support.

Both of her parents are deceased. Mrs. C says that her father was an alcoholic in his early years before became a Christian. She led him to the Lord. She feels a special closeness with him. Mrs. C said that she has always felt more comfortable with men than with women and she attributes that to her closeness to her father. He was killed in an automobile accident. Her mother was not a very outgoing individual. She preferred to stay at home most of the time. She died of a stroke, which runs in the family.

The client is the oldest of four children. She had two sisters and a brother. They all died as a result of a stroke. Because strokes tend to run in her family, Mrs. C is very fearful of strokes (more so than cancer).

Mrs. C has many friends. She still stay in contact with friends from Temple where she once resided. In Waco, her main source of social contact is through her church, First Baptist Waco. In an emergency, she would call on Mrs. Marilyn Bishop (798-2027), Ellen Powell (789-7950), and her neighbor, Judy Anderson (772-6249).

Currently, Mrs. C has three others living with her --- her granddaughter and her two great granddaughters. Her granddaughter, Anna, has diabetes. Laurie and Amanda are her great granddaughters. They are 10 and 13 years old respectively.

Mrs. C is very active in First Baptist Waco involved in the Women Ministry Union (WMU), Staying Active Longer (SAL), Good Timers, and Homebound ministry. She also volunteers at the crisis center and the V.A. hospital. She has volunteered at the V.A. once a month for at least 8 years.

IV. EDUCATIONAL AND EMPLOYMENT INFORMATION

Mrs. C graduated from Waco High School when it was still located on Columbus Avenue. She went to beauty school after that and became a beautician. She quit working to raise her children. Later, she started work again with the encouragement of a friend. She worked for Cox's and retired from there in 1973.

V. MILITARY AND LEGAL INFORMATION

Mrs. C was not in the military, but her husband served in the Army for 30 years in personnel for the Army Medics. He was sent on active duty during the Korean War. She does not receive a pension from the Army because her husband neglected to do the paper work before his death. The only money she receives, other than her social security check of $402 a month, is $100 per month from the Red Cross through the Army Emergency Relieve Fund.

VI. MEDICAL INFORMATION

Mrs. C receives her medical treatment from Fort Hood. The government pays for her medical expenses. She said that if the government did not pay for her medical expenses she would not be able to afford medical treatments and medications. She does not really have a particular physician of her own there; however, she does have a specialist for her heart condition. His name is Dr. Juarez. She has hypertension, breathing difficulties, swelling of the feet, an intestinal condition, a heart condition, and arthritis. She takes medication for all those conditions. Despite all her ailments, she describe her general health as fair. She says that the only thing that really gives her trouble is her arthritis. Special attention is needed to monitor her hypertension since a history of strokes do run in her family. She did not have the flu during 1922-1923; however, the flu affects her badly at least twice a year. She had an allergic reaction to her heart medication. That was remedied when the dosage was reduced on the advice of her physician. Mrs. C has never received psychiatric treatment. Mrs. C says that she seldom has a problem with anger. She handles her anger through the use of prayer. She does not have difficulty sleeping, eating, remembering, or falling. She is very stable on her feet and very oriented. Despite her vision impairment, she manages to get around in her home very well. Prior to developing macular degeneration, Mrs. C walked regularly with a walking program through First Baptist Waco.

She conveyed to me that her happiest experience was when she led her own father to the Lord. Her second happiest experience is when she had a "miraculous" recovery from her recent stroke. She says that it was an answer to prayer. Both of her most traumatic experiences involved surgeries. The first was when daughter had a ear problem while her husband was overseas. She had to decide whether surgery should be performed. The second involved her great granddaughter's throat surgery.

VII. ACTIVITIES

Mrs. C is an extremely active lady. She regularly attends all her church activities and volunteer work which were mentioned above. She also socialize with her friend through the telephone. Several times a month, they would come take her out to lunch, to go shopping, or to just visit at their home. To keep herself occupied while she is at home, she does household chores like cleaning, ironing, and cooking. She says that she use to occupy her time with reading. But ever since her vision impairment, she had to do other things to fill her time. Functionally, Mrs. C can take care of all her activities of daily living. She is dressed well. Her home is clean and well-kept. She can manage her medication well. Assistance is required for transportation and financial matters such as bill payment and form filling which her granddaughter does for her.

VIII. LEISURE ASSESSMENT

Mrs. C enjoys her time with her great granddaughters. They provide her with a great source of joy. In her spare time, she used to read. Now, she listens to types. She continues to collect clocks, which was a hobby of her husband's. To relax, she sleeps.

IX. ASSESSMENT

Physically, Mrs. C is in fair health considering the variety of medical conditions that she has --- hypertension, swelling of the feet and ankles, macular degeneration, intestinal problems, and arthritis. She has managed all of these conditions well. Her arthritis and vision impairment seem to affect her the most. She is seeking help in obtaining equipment that will assist her to read. That is the pressing issue at this time. Mrs. C is open to receiving information and assistance that may help improve her ability to see.

Mrs. C is alert, oriented, and active. She is actively involved in her church and in the community. Family, friends, and neighbor provide her with social and emotional support. They also assist her in areas that she is no longer able to do such as paying bills, reading, and filling forms. Her major source of strength is her faith in God. Her faith touch virtually all aspects of her life. Emotionally, Mrs. C is very stable. She does not anger easily. Mood strings are not evident.

Mrs. C's strengths are determination and physical stamina. She is capable of caring for herself and for her family. She has a healthy, positive attitude toward life. She enjoys life and tries to make the most of it regardless of the circumstances. She said to me that she lives the best she can with what she has every day for God.

X. RECOMMENDATION

The presenting issue for Mrs. C is her adjustment to her vision impairment caused by macular degeneration. To help her to read again, a close-circuit projection device is required. Efforts should be made to obtain the funding necessary to purchase this device. Sources of funding to be investigated are the Texas Commission for the Blind, her church, and her friends. Meanwhile, the client should be referred to Friends For Life for the Adopt a Grandparent program. Close monitoring of Mrs. C's hypertension is necessary (she is at high risk of another stroke because this condition runs in her family). Dr. Juarez, her physician at Fort Hood, can administer that.

XI. CARE PLAN

Needs:	Resources:
1) funding for closed-circuit projection device	1) Texas Commission for the Blind her church (First Baptist Waco) her friends
2) someone to read to her in her home	2) Friends For Life (Adopt-a-Grandparent program)
3) monitoring of hypertension	3) Dr. Juarez at Fort Hood

SAMPLE CASE MANAGEMENT ASSESSMENT AND CARE PLAN

Many case management programs for older adults utilize standard instruments to assess a client's functional status, social support system, financial resources, as well as relevant psychosocial issues. The format of these instruments can assist in the development of a care plan which specifies a client's problems, the type of help needed, as well as the proposed pattern of service response involving either formal services from agencies or assistance from family, friends, or other informal support resources. The following forms represent a hypothetical client served by a case management program in Houston. Although the information is fictitious, the approach to the assessment and care plan are consistent with the services of the agency.

These forms were completed by Delores Garcia in her capacity as a case manager.

HOUSTON
REVISED 5-85

ASSESSMENT SUMMARY FACE SHEET

Client's Name A.K. Jones Date of Assessment 06-12-85

Address 1224 Green Case Manager

Phone 723-1405 Referral Source Mary Smith, R.N. (Goodcare Home Health)

Birthdate 08-10-07 age 77

Sex: ___ Male ✓ Female

Marital Status: ___ Married ✓ Widow ___ Single ___ Separated ___ Divorced ___ Unknown

How long 20 years

Race ___ Education 11th grade Other Language (If not English) ___

Emergency Contact Lillie Lester

Doctor's Name Dr. Allen Hannah Phone 771-2233

Address 1000 Capital Hospital Harris General Hospital

Doctor's Name ___ Phone ___

Address ___ Hospital ___

Living Arrangement ✓ Alone ___ Spouse ___ Other ___

Children/Family (Name)	Address	Phone
Lillie Ruth Lester	7223 Boyd	937-2121

Health Coverage: Medicare ✓ A ✓ B ___ Medicaid ___ Other

WA 201-74-0603 # SS 464-01-9963

Resources:	Client	Spouse
Social Security	243.00	
SSI		
Other Retirement	150.00	
Equity	200.00	
Total Income	$ 593.00	
Household	$ x	
Food Stamps	$ x	

Expenses:	
Housing (Rent)	100.00
Utilities	111.00
Food	100.0
Medical Bills	
Medicine	100 00
Insurance	44.0
Other	25.0
Total Expenses $	48.

Illnessess and Health Conditions:

Do you have any of the following illnesses or helath conditions? If yes, are you currently being treated for this?

a) Glaucoma, cataracts or other eye problem?

b) Hearing problem?

c) Asthma, emphysema, bronchitis or other breathing problem?

d) Angina or heart trouble (heart attacks)? High blood pressure?

e) Paralysis or effects of a stroke?

f) Ulcers or other stomach problems?

g) Broken or dislocated bones?

h) Arthritis or pain in your joints?

i) Skin problems like a rash, eczema or bedsores?

j) Anemia (iron-poor blood, tired blood)or other blood disease?

k) Diabetes?

l) Cancer, Leukemia or a tumor?

m) Other health condition or illness?

ALCOHOL:

Do you drink alcohol? How much? How often?

Have you ever been advised by your doctor to cut down on your drinking? Describe.

SMOKING:

Have you ever smoked? Ex-smoker? Packs/day? Smoking history?

If smoker currently, is the person able/capable of smoking safely, without endangering the safety of others? Smokes in bed?

DRUGS:

Do you use drugs? How frequently? What kinds?

I would like some information about the medicines you take regularly now. Let's start with your prescriptions. (May I see them?)

AFTER PRESCRIPTIONS NOTED,
Are there any other medicines you keep in a special place, for example in the refrigerator, or any special medicines like eyedrops, suppositories or injections?

AFTER ANY SPECIAL MEDICINES NOTED.
Are there any non-prescription medicines you take regularly like vitamins, aspirin, or laxatives?

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Name A. K. Jones

PHYSICAL HEALTH

Medical Conditions: Congestive Heart Failure, Hypertension, S/P Amputation due to leg ulcer, Arthritis and Decubitus (sacral area)

Continence: ____ Yes ✓ No Has an indwelling foley catheter

Nutrition: Fair appetite / Usually eats well balanced Entrée Wt. 130 lbs

Health Care	# Times 6mos.	Last Visit	Reason
Doctor			
Hospital	(1) 3/12 - 4/5/85	4/5/85	Amputation
Nursing Home	(1) 4/5 - 6/5/85	6/5/85	Rehabilitation

MEDICINE	DOSAGE	FREQUENCY	DOCTOR	DATE
Lopressor (?)	75 mg.	tid	Hamad	6/5/8
Hydrazine	1 mg.	tid	"	"
Tylenol	325 mg.	prn	"	"
Theo Dur	200 mg.	bid	"	"
Reglan	10 mg.	Supplements & at bedtime	"	"
Feldene	20 mg.	qd	"	"
Lanoxin	.125 mg.	qd	"	"

	Needs	Uses	Problems
Dentures	✓	✓	too large
Hearing Aid			
Glasses/Lenses	✓	✓	
Wheelchair/walker	✓	✓	
Hospital Bed			
Commode	✓	✓	uses at night only.
Prosthesis	✓	✓	
Medical Treatment at Home	✓	✓	
Other			

Vision: Good / last eye in 1982.

Hearing: fair / must speak clearly

Kind: Turning to correct

Kind: Catheter maint

Mobility Wheelchair bound

Homebound Invalid Needs asst./escort due to limited

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a. Do you often have trouble getting to sleep or staying asleep?.... ___yes ✓no

b. Do you often find yourself feeling unhappy or depressed?..... ___yes ✓no

c. Are you troubled by your heart pounding or shortness of breath?.. ✓yes ___no

d. Do you usually have a good appetite?..... ___yes ✓no

e. Have there recently been times when you couldn't "get going"?.... (you were constantly tired)..... ✓yes ___no

f. Have you had crying spells or problems shaking off the blues?... ___yes ✓no

g. Do you often have trouble keeping your mind on what you are doing ___yes ✓no

Sometimes when people get older, they have trouble remembering things. If you do not know the answers to some of the next questions, that's okay. It's very normal. If you do know the answers, the questions may seem obvious.

	CORRECT	INCORRECT OR NOT ANSWERED
a. What is the date today?..... 04-12-85	(01)	02
b. What day of the week is it?..... Wednesday	(01)	02
c. What is the name of this place?..... PROBE: This neighborhood? This apartment (house/project)? Robinsville	(01)	02
d. What is your telephone number? IF CLIENT DOES NOT HAVE A PHONE, What is your street address?.....	(01)	02
e. How old are you?..... 77	(01)	02
f. When were you born?..... MO. 08 DAY: 10 YR: 07	(01)	02
g. What is the name of the President of the United States?..... Reagan	(01)	02
h. Who was president before this one?..... Carter	(01)	02
i. What was your mother's maiden name?..... Harmsley ACCEPT ANY SURNAME OTHER THAN CLIENT'S.	(01)	02
j. Sutract 3 from 20 and keep subtracting 3 from each new number you get, all the way down..... PROBE: Can you subtract 3 from that?	(01)	02

17, (14), (11), 8, 5, 2

	No	With Help	Independent	Adequate	Inadequate	No	Other Information
Feed Self			✓				
Get In/Out of Bed			✓				
Dress/Undress			✓				Does not put stret. Etc
Bathe/Shower		✓			✓		
Shave N/A							
Use Toilet (Gets to Bathroom)			✓				
Cook Meals	✓				✓		
Light Housekeeping	✓				✓		
Heavy Housework	✓				✓		
Laundry	✓				✓		
Shop	✓						
Take Medicine			✓				
Walk Inside	✓						
Walk Outside	✓						
Transportation		✓					
Handle Money			✓				
Use Telephone			✓				

SERVICES AND SUPPORT

A. Informal Supports	Address/Phone	Current Help/Frequency
1. Willie Wilkerson (friend)	5055 Head Blvd / 623-1986	Meals / prn
2. Lillie Lester (daughter)	7233 Boyd / 937-2121	Household maintenance, shopping + errands 1-2x/wk
3.		

B. Formal Supports	Address/Phone	Current Help/Frequency
1. Gardcare Home Health (Mary Beth RN)	1000 W-Beth Expy / 333-2100	Skilled Nurse Visit 1/2x
2. Gardcare Home Health (Dorothy)	" "	Home Health Aide 1/3x
3. Gardcare Home Health		Physical + Occupational Therapy

PSYCHOSOCIAL

A. Emotional Status

Sometimes	Often	COMMENTS:
✓		Feeling Lonely
		Sleeping Problems
		Worried, Anxious
		Irritable, Easily Upset
		Loss of Interest in Things

B. Intellectual Functioning Alert, oriented x 3, appropriate responses. SPMSQ SCORE 10

HISTORY

What was your occupation? Dietician

When did your retire? June 1970 - due to arthritis

Amount of time at present residence. Since 1969

When did you move to Houston? 1930

Relationships

Where were you born? Nacodaches, Texas

STRESSFUL EVENTS:

If client has mentioned a item earlier in the interview do not ask again.

In the past year, have you married, been widowed, divorced, or separated?
Have you been hospitalized or experienced a major illness in the past year?
Have you suddenly become unable to do things you used to be able to do?
Have you moved? Against your wishes?
Anything else?

Regarding each item, ask:
How has this affected you?

C. History See Admission Summary

D. Social/Religious Activities Pastor visits twice monthly.

E. Interests/Hobbies Cooking, Sewing and Knitting

Physical Environment: Good

Recent Major Changes Surgery - loss of independence.

Information from Other Sources Kerr

STRESSFUL EVENTS IN PAST YEAR	Yes	No	NARRATIVE: (Does client view the even postively or negatively?
Death of close friends or family members		✓	
Change in marital status (married, widowed, divorced)		✓	
Hospitalization or major episode of illness	✓		
Major change in functioning status	✓		
Relocated/moved		✓	
Other			

TOTAL STRESSFUL EVENTS = 2

NAME A. K. Jones

SUMMARY Mr. Jones was referred to the Aging Connection by Mary Smith R.N of Gradcare Home Health. Mr. Jones was discharged from St. Anthony's Rehabilitation Center on June 5. He had been at the center for two months, prior to that one month was spent in Harris General Hospital. Mr. Jones had complications from slow healing leg ulcers which resulted in amputation of that leg. The client is now bilaterally wheelchair bound. Other medical problems include arthritis, hypertension, congestive heart failure and decubitus ulcers. Mr. Jones also has an indwelling catheter. Assistance is now needed with some ADL and IADL tasks.

Mrs. Jones is a retired dietician who worked in an elementary school for many years. She has been a widow for 20 yrs. Her only child is Lillie Lester, a nurse at Ben Taub Hospital. Mrs. Jones is originally from Waxahachie, Texas, she moved to Houston in 1930.

Mrs Smith wishes to continue living in the small home she rents. Presently, she is receiving services from Gradcare Home Health. A skilled nurse visits 2x weekly and a HHA visits three times weekly with personal care. Physical and Occupational Therapy is to be received for two weeks, both will visit twice weekly.

PRIMARY CAREGIVER: _____ RELATIONSHIP _____ REFER TO CAREGIVER GROUP _____

CAREGIVER NEEDS/PROBLEMS: _____

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CLIENT A K Jones

NEXT REASSESSMENT

TEXAS PROJECT FOR ELDERS CARE PLAN

PROBLEM	CODE	DESIRED OUTCOME	TYPE OF HELP NEEDED	CODE	SERVICE/PROVIDER: INFORMAL	SERVICE/PROVIDER: AGENCY	CODE	PATTERN OF DELIVERY: REQUESTED	PATTERN OF DELIVERY: ACTUAL	SERVICE INITIATION DATE
Needs medical monitoring due to fragile health and catheter maintenance			Skilled nurse visits for medical monitoring			Indep Living Health-RN		2 x wk	2 x wk	
Limited mobility due to recent amputations			Physical therapy to increase strength + endurance			Independent Health-PT		2 x wk	2 x wk	
Needs assistance with assistive devices due to limited mobility			Occupational therapy to increase ADL + IADL skills			Independent Health OT		2 x wk	2 x wk	
Needs assistance with personal care			Assistance with bathing dressing and grooming			Independent Health Aide		3 x wk	3 x wk	
Assistance needed with household maintenance			Assistance with housekeeping, clean laundry, and grocery shopping		Sallie (Daughter)			as needed	1-2 x wkly	
Needs assistance with meal preparation		Client will receive two balanced meals as soon as possible	Nutritious meals daily		Sallie (friend)	Meals on Wheels		Requested 6/15/88	1-2 x wkly	
Needs additional assistance with household maintenance		Client will receive assistance with household maintenance as needed	Asst. with heavy household tasks			Independent Contr		Requested 6/15/88		
Fragile relation due to poor health		Case manager will assist as needed. Client will receive 1 x wk visit	Assessment & referrals as necessary as needed			Texas Case Manager		as needed	as needed	

PROBLEMS NOT ADDRESSED AND WHY:

SERVICE GAPS:

MONITORING:
Client will contact Case manager as needed. Case manager to contact Client 2-3 x monthly.

CASE MANAGER DATE

SUPERVISOR DATE

Submitted by: Dr. Ellen Stevens
Assistant Professor
Graduate School of Social Work
University of Houston

SOCIAL WORK SERVICES WITHIN A HOME HEALTH AGENCY

The purpose of the social work function at Sample Hospital Home Health Agency is to provide psychosocial services to help patients and their families cope with effects of acute or chronic illness.

The philosophy with which this work is carried out is consistent with the agency's philosophy of non-abandonment. We strive to provide continuity of care so that the patient and family may benefit from Sample's Home Care Agency, Outpatient Department, and Inpatient Services. The patient-family system is the unit of treatment and patient's self-determination is the guiding direction for service provision.

The Home Care Social Worker provides the following services:

(1) assessment of social and emotional factors; (2) counseling; (3) financial assistance; (4) placement assistance; (5) arrangement of meals; and (6) bereavement follow-up services are provided to family members of deceased home care patients.

Home visits enable the Medical/Home Care Social Worker to conduct an "on-site" assessment of the patient's physical and social environment, quality of interaction with family members, and residential community. Additional home visits enable follow through on the treatment plan as well as ongoing assessment. Telephone contacts with patients, family members, significant others, and personnel from community resources facilitate service provision. Participation on the interdisciplinary home care team and case management conferences foster team work and joint planning.

As the patient census more than tripled from April 1986 to April, 1987, additional professional social work staff was requested. Fee-for-service Social Workers were obtained to make home visits as needed. In March, 1988, a Social Work Assistant was hired to focus on financial assistance. A financial assessment report was recently developed as an assessment tool for the Social Work Assistant.

Since the inception of the Home Health Agency, the professional staff has increased to address the growing population of patients and families. The Social Work function is challenged to keep up with Agency growth and patient needs. During 1988, the Agency will continue to increase its staffing of Social Work and Pastoral Care support services to its patients and their families.

Case Example:

Mrs. M was a 50-year old married woman with cancer of the thyroid. She resided with her husband and had minimal contact with friends or family members. Financial resources consisted of income from husband's employment, patient's pension and limited savings.

Psychosocial assessment indicated that patient and husband were eligible for financial assistance from private organizations - American Cancer Society and Cancer Care, Inc. Patient appeared to be depressed in response to her illness; counseling services were provided by the Agency's social worker and subsequently from a community mental health agency. Music therapy also addressed the patient's psychological needs. Volunteer services were provided for "friendly visiting" and pastoral care to meet spiritual needs.

The Medical Social Worker collaborated with the Community Health Nurse providing services, the Home Health Aides and the Physical Therapist. When the patient was admitted to Sample Hospital, the home care social worker visited the patient and facilitated the transition to hospital care.

Following this patient's death in Sample Hospital, the home care social worker provided bereavement follow-up services to the patient's husband.

GERIATRIC ASSESSMENT METHODS FOR CLINICAL DECISIONMAKING

National Institutes of Health
Consensus Development
Conference Statement

Volume 6 Number 13
October 19-21, 1987

Introduction

The population of elderly persons in the developed nations is growing with extraordinary rapidity. Although the majority enjoy good health, many older people suffer from multiple illnesses and significant disability. Comprehensive assessment methodologies, while not solely applicable to frail elderly persons, are believed to be particularly suited to their situation. These individuals tend to exhibit great medical complexity and vulnerability; have illnesses with atypical and obscure presentations; suffer major cognitive, affective, and functional problems; are especially vulnerable to iatrogenesis; are often socially isolated and economically deprived; and are at high risk for premature or inappropriate institutionalization.

To deal with the exceedingly difficult health care issues posed by frail elderly persons, health professionals need to collect, organize, and use a vast array of clinically relevant information. This process, comprehensive geriatric assessment, is defined as a multidisciplinary evaluation in which the multiple problems of older persons are uncovered, described, and explained, if possible, and in which the resources and strengths of the person are catalogued, need for services assessed, and a coordinated care plan developed to focus interventions on the person's problems.

Comprehensive geriatric assessment generally includes evaluation of the patient in several domains, most commonly the physical, mental, social, economic, functional, and environmental.

The term "functional" is used here in a narrow sense: It means the ability to function in the arena of everyday living. The panel recognizes that the same word has been used in the much broader sense of the whole range of functions we have listed just above. In other words, some use "functional assessment" to mean what we have termed "comprehensive geriatric assessment."

When applied to clinical decisionmaking, comprehensive geriatric assessment involves clinicians from the many health care professions who are necessarily involved in good geriatric care. Comprehensive geriatric assessment is only one component of general geriatric care. Appropriate geriatric care involves some level of assessment of the multiple domains just cited, but comprehensive geriatric assessment tends to be applied only to a subset of older persons who are frail and considered most likely to benefit (see question 3). It has been suggested that a new form of comprehensive assessment could be developed to evaluate physical fitness for purposes of monitoring health promotion and disease prevention in well older persons and another form to guide the humane care of irreversibly disabled and terminally ill older persons.

Between 1973 and 1987, reports have appeared on a significant number of true experiments exploring the elements and effectiveness of various approaches to geriatric assessment. The data from these studies, coupled with the growing numbers of frail elderly individuals, the high cost of their health care, the intensity of their distress and discomfort, and the great uncertainty as to the best route to wise clinical decisionmaking, led to the current conference. The National Institute on Aging and the Office of Medical Applications of Research of the National Institutes of Health, in conjunction with the National Institute of Mental Health, the Veterans Administration, and the Henry J. Kaiser Family Foundation, convened the Consensus Development Conference on Geriatric Assessment Methods for

The National Institutes of Health urges that this summary statement be posted, duplicated, and distributed to interested staff.

Clinical Decisionmaking on October 19-21, 1987. After a day and a half of presentations by experts in the field, a consensus panel including methodologists and representatives of medicine, nursing, social work, and the public considered the scientific evidence and developed answers to the following central questions:

1. What are the goals, structure, processes, and elements of geriatric assessment for clinical decisionmaking?
2. What are the comparative merits of different methods in carrying out a geriatric assessment?
3. What is the evidence that a geriatric assessment is effective? If so, in what settings, for whom, and for which outcomes?
4. Insofar as a geriatric assessment is effective, what linkages to clinical management systems are required?
5. What are the priorities for future research in geriatric assessment?

Comprehensive geriatric assessment has been used for many nonclinical purposes, including research, education, health policy, and administration. This report focuses only on its use for clinical decisionmaking.

1.

What are the goals, structure, processes, and elements of geriatric assessment for clinical decisionmaking?

Goals

The goals of comprehensive geriatric assessment are: (1) to improve diagnostic accuracy, (2) to guide the selection of interventions to restore or preserve health, (3) to recommend an optimal environment for care, (4) to predict outcomes, and (5) to monitor clinical change over time.

Structure

Comprehensive geriatric assessment may be done in many institutional settings, including acute care, psychiatric, or rehabilitation hospitals and nursing homes, and in ambulatory settings, including outpatient or freestanding clinics, the offices of primary care physicians, or in the patient's home. It often has been applied to elderly persons at critical transition points in their lives, including actual or threatened decline in health and functional status, impending change in living environment, bereavement, or other unusual stress.

Processes

Comprehensive geriatric assessment is initiated by a referral from one of a number of sources (see question 4). In addition to the patient, the process often includes family members and other important persons in the individual's environment. It is conducted by a core team that consists, at a minimum, of a physician, nurse, and social worker, each with special expertise in caring for older people. Frequently, a psychiatrist is a member of the core team. The specific activities and contributions of each team member may vary considerably, and flexibility in roles may facilitate the assessment process.

The assessment begins with a case-finding approach that utilizes screening instruments and techniques. Based on these initial findings, a more detailed assessment is frequently undertaken. This indepth assessment often requires the participation of a number of other professions. These may include audiology, clinical psychology, dentistry, nutrition, occupational therapy, optometry, pharmacy, physical therapy, podiatry, speech pathology, and the clergy. Support from other medical disciplines, such as neurology, ophthalmology, orthopedics, physiatry, surgery, and urology, is commonly needed.

Some aspects of geriatric assessment may be provided by self-rating scales completed by the patient or caregivers. Such information may lead to different insights than those obtained through external assessment performed by a member of the health care team.

Elements

Physical Health

A careful history is obtained from the patient and others with significant knowledge of the patient. Special attention is directed to the use of prescription and nonprescription medications and clues to the presence of malnutrition, falling, incontinence, and immobility. Data are gathered on smoking, exercise, alcohol use, immunization status, and sexual function. Also important is information regarding the patient's personal strengths, values, perceived quality of life, acceptability of interventions, and expected outcomes from his or her health care.

A physical examination is performed with emphasis on identification of specific diseases or conditions for which curative, restorative, palliative, or preventive treatment may be available. Special attention is directed toward visual or hearing impairment, nutritional status, and conditions that may contribute to falling or difficulty in ambulation. Laboratory tests and other diagnostic studies are obtained as indicated.

Mental Health

Cognitive, behavioral, and emotional status are evaluated. Detection of dementia, delirium, and depression is particularly important. A range of assessment instruments is available for these purposes. For some patients a detailed psychiatric interview, a neurobehavior consultation, or comprehensive neuropsychological testing is indicated.

Social and Economic Status

Evaluating the social support network includes identifying present and potential caregivers and assessing their competence, willingness to provide care, and acceptability to the older person. This information may be obtained by questionnaires, structured interviews, or other methods. The degree of caregiver stress and the caregiver's support network also are considered.

Areas of special importance to the individual, such as cultural, ethnic, and spiritual values, are noted. The individual's own assessment of the quality of life is recorded. The clinician evaluates the economic resources of the elderly person, which often determine access to medical and personal care and influence options for living arrangements.

Functional Status

There are several components to a comprehensive assessment of an older person's ability to function. Physical functioning is measured by the ability to accomplish basic activities of daily living (ADL), including bathing, dressing, toileting, transferring, continence, and feeding.

Other components of functional well-being are behavioral and social activities that require a higher level of cognition and judgment than physical activities. These instrumental activities of daily living (IADL) include preparation of meals, shopping, light housework, financial management, medication management, use of transportation, and use of the telephone.

Functional status (ADL and IADL) is probably most accurately evaluated by direct observation of the patient by family or health professionals in the home or a simulated homelike environment. However, surprisingly accurate information is also obtained by standardized questionnaire or self-report.

Environmental Characteristics

Evaluating the patient's physical environment is essential. Home visits and questionnaires are used to determine the safety, physical barriers, and layout of the home as well as access to services, such as shopping, pharmacy, transportation, and recreation.

Development and Implementation of a Care Plan

Comprehensive geriatric assessment is a dynamic, ongoing process. After the initial assessment, the team generates a comprehensive list of the patient's needs and strengths, usually at a multidisciplinary case conference. Recommendations are integrated into an individualized plan of interventions and desired outcomes. The preferences of the patient and family must be especially carefully considered at this stage in the process. If the assessment takes place in an inpatient facility, treatment and rehabilitation are often initiated in that facility, sometimes directly by members of the team on a specialized unit. In consultative models, the team's recommendations are transmitted to the appropriate primary care providers. Regardless of the site of assessment or the primary responsibility for implementation of the recommended regimen, periodic reassessment and appropriate modification of the care plan are central elements of the process of comprehensive geriatric assessment.

2.

What are the comparative merits of different methods in carrying out a geriatric assessment?

Many assessment methods for specific domains have undergone rigorous validation, and the criteria for acceptance of a given method have been carefully defined. However, in domains in which there are multiple validated instruments to measure the same function, there have not yet been studies that directly compare one method to another. As a result, identification of the single best instrument in each domain is not possible at this time. One of the first steps in establishing a program of geriatric assessment is deciding upon a standardized approach to data collection. Before choosing from among the different methods, clinicians should consider some of the following issues.

In the context of comprehensive geriatric assessment, there is a role for both structured and unstructured methods of data gathering. There are several merits of a structured approach. Precision, reproducibility, and freedom from bias are enhanced by using standardized validated questions and requiring the respondent to choose from a limited number of answers. The task of data collection is more easily delegated if the format is standardized. Standardized data collection methods help in clinical decisionmaking and prospective evaluation of the efficacy of

interventions. On the other hand, merits of unstructured methods include flexibility of the testing procedure, ability to probe problems in detail, and the opportunity for synthesis of findings to develop a global impression.

A number of assessment instruments have been shown individually to have good reliability and validity. A reliable instrument is internally consistent and provides the same evaluation of the patient when used by different raters. A valid instrument measures correctly the domain being investigated. In addition to quantitatively measured validity and reliability, an instrument should have face validity (i.e., on the "face of it" the instrument appears to measure the domain correctly). Although some characteristics of patients who will benefit from a given type of assessment have been identified, there are no validated instruments for predicting benefit.

One approach to developing a comprehensive geriatric assessment program is to select one of several multidimensional instruments designed to address all major domains of geriatric assessment. Alternatively, specific assessment instruments developed for each domain can be combined to accomplish a comprehensive assessment. There is no evidence that either approach is superior to the other.

Desirable characteristics of instruments for case finding are efficiency, simplicity, flexibility for use under a variety of circumstances, and portability. Case finding requires less sophistication from the examiner than indepth assessment and is relatively inexpensive. There are reliable and valid instruments with which to assess mental function, socioeconomic status, and ADL. Each instrument has a specific range of usefulness. For example, assessment of ADL reliably detects advanced degrees of functional impairment but is quite unlikely to detect minimal departures from normalcy.

Indepth geriatric assessment methods need to have high predictive value, detect small changes in function, identify potentially remediable problems, and efficiently predict patient outcomes. Special expertise is often required to carry out an indepth assessment.

Three additional issues should be addressed. First, indepth assessments (and consequent interventions) must take patients' values into account. Second, comprehensive assessment methods should accurately reflect change in patient status over time. Most existing methods do not meet this need. Finally, while it is possible to educate a variety of health care professionals to carry out various aspects of comprehensive assessment, experience and leadership are required in the individual or individuals responsible for supervising the assessment effort.

3.

What is the evidence that a geriatric assessment is effective? If so, in what settings, for whom, and for which outcomes?

Accumulated evidence indicates with moderate-to-high confidence that comprehensive geriatric assessment is effective when coupled with ongoing implementation of the resulting care plan.

The settings in which effectiveness has been convincingly demonstrated are the combined geriatric assessment and rehabilitation unit and the inpatient geriatric assessment unit. There is less consistent evidence regarding the effectiveness of comprehensive geriatric assessment in the home, ambulatory setting, and the hospital inpatient consultation service.

As practiced, comprehensive geriatric assessment has been demonstrated to be effective for a variety of desirable outcomes. Studies to test effectiveness have varied in design from descriptive (before versus after) to match control to the most persuasive form, randomized controlled trials.

Outcomes favorably affected by comprehensive geriatric assessment, as demonstrated by randomized controlled trials, have included improved diagnostic accuracy, prolonged survival, reduced annual medical care costs, reduced use of acute hospitals, and reduced nursing home use. These have been most consistently demonstrated. Less consistently reported benefits include increased use of health and social services delivered in the home, reduced medications, and improved placement location, affect and cognition, and functional status. Other outcomes of great importance (e.g., quality of life) have not been studied adequately.

Two aspects of comprehensive geriatric assessment appear to be of central importance. The first of these is targeting of the process to those persons most likely to benefit, a feature of most successful programs and one strongly endorsed by experienced progam leaders. In the inpatient setting, targeting has focused on patients over age 75 and those with potentially reversible disabilities. This target group may account for as much as 10 to 25 percent of hospitalized elderly patients. Most studies demonstrating

effectiveness have excluded groups whom the investigators thought least likely to benefit, notably persons who are fully independent and those with end-stage disease or disability. Several programs have focused on elderly persons at points of transition or instability, as cited under question 1.

The role of targeting in comprehensive geriatric assessment conducted outside the hospital setting is less clear. Certain U.S. studies have failed to demonstrate favorable outcomes in ambulatory settings. This result may be attributable to ineffective targeting. However, two European studies of randomly selected, community-dwelling persons reported efficacy of comprehensive geriatric assessment without targeting other than for advanced age, suggesting the possibility of expanding the use of these techniques to a broader population in this country.

The second important aspect of comprehensive geriatric assessment appears to be the link between assessment and followup services (also discussed under question 4). Successful programs have been able to assure adoption of treatment recommendations reached during the initial assessment. In some programs, the assessment team has assumed direct control over treatment of the patients, while in others the followup has involved active and ongoing consultation and communication with primary care providers. The failure to provide sufficient linkage between assessment and followup may provide another explanation for negative results reported in certain studies. In addition, these negative results may be due to an insufficiently comprehensive assessment or intervention (e.g., failure to include medical evaluation) or to the use of instruments insensitive to changes that actually may have occurred.

Additional elements of the comprehensive geriatric assessment to which effectiveness has been attributed by developers of successful programs deserve attention. Such elements include focus upon content areas in which geriatric expertise is acknowledged: malnutrition, mental impairment, immobility, iatrogenesis (notably polypharmacy), impaired homeostasis, and incontinence. Furthermore, the effectiveness of the comprehensive geriatric assessment appears to be more than the sum of its parts, perhaps because of the integrative nature of the process and the multidisciplinary discussion that translates the information gathered into a rational plan of care. Finally, it has also been suggested that the effectiveness of comprehensive geriatric assessment is at least partly attributable to the enthusiasm and caring attitude of those who have developed these programs.

4.

Insofar as a geriatric assessment is effective, what linkages to clinical management systems are required?

Comprehensive geriatric assessment programs should not be viewed as operating independently from other elements of the health care system. Geriatric assessment is a dynamic process responsive to the changes in health status that occur over time. Therefore, a method for assessing effectiveness of interventions over time and for detecting new problems must be provided. A broad approach is needed to ensure that community case finding identifies the at-risk population and links comprehensive geriatric assessment to subsequent provision of services.

In the absence of a community case-finding program, patients are referred for comprehensive geriatric assessment from a variety of sources, most commonly relatives and community service agencies. Less common sources of referral are the patients themselves, friends, and physicians. Health maintenance organizations and other managed care organizations, as well as nursing homes, may be increasingly important referral sources in the future.

Ongoing monitoring of the implementation of recommendations made during comprehensive geriatric assessment is believed to be central to the success of the care plan. The role of linkages to clinical management systems in the effectiveness of comprehensive geriatric assessment has not been directly tested. However, continuing personal contact of hospital geriatric assessment consultants with the patients and their primary providers does appear to facilitate the implementation of recommendations. Case management as a process to provide linkages is available in many communities, and its role in ensuring followup of recommendations requires further investigation. Clearly, the availability of a wide array of social services is a requirement for successful implementation of a comprehensive geriatric care plan.

5.

What are the priorities for future research in geriatric assessment?

Although past research on comprehensive geriatric assessment has provided much valuable information, many questions remain unanswered. Existing studies have demonstrated that effective services can be provided, but these services consist of combinations of activities that have been selected on an empiric

basis. Future research can define more carefully which elements of these packages—perhaps all of them—contribute importantly to achieving the observed results. Earlier studies have been site-specific and have incompletely assessed the range of patients who might benefit from these activities. Finally, important measurement problems persist. Thus, key future steps in research include the following:

- Conduct multicenter, randomized controlled trials of comprehensive geriatric assessment, including both academic and nonacademic settings, addressing the above-cited gaps in our knowledge.
- Extend the use of randomized controlled trials of comprehensive geriatric assessment to other outcomes, particularly quality of life, effect on family, and cost-effectiveness.
- Extend the use of randomized controlled trials of comprehensive geriatric assessment to other settings, particularly the home and the nursing home.
- Determine the most effective means for targeting of comprehensive geriatric assessments in a broad patient population.
- Use controlled trials of comprehensive geriatric assessment to evaluate the effect of different combinations of personnel, instruments, and interventions.
- Compare the effects of assessment with and without various methods for coordinated implementation of the care plan.
- Develop new assessment tools for measuring levels of and changes in functional status, particularly for those with mild-to-moderate levels of impairment.
- Directly compare instruments that assess information within the same domain.
- Develop data bases with which to establish patterns of changing function, especially in persons who spend time in long-term care institutions.

Conclusions

The settings, uses, processes, personnel, and component domains of comprehensive geriatric assessment have been defined with sufficient clarity to provide guidelines for establishment of new assessment programs.

Accumulated evidence indicates with moderate-to-high confidence that comprehensive geriatric assessment is effective when coupled with ongoing implementation of the resulting care plan.

Effectiveness has been most convincingly demonstrated in two inpatient settings, the geriatric assessment unit and the combined geriatric assessment-rehabilitation unit.

The most consistently demonstrated favorable outcomes of comprehensive geriatric assessment have been prolonged survival, reduced annual medical care costs, and reduced use of acute hospitals and nursing homes.

Although the evidence allows for alternative interpretation, it is probable that careful selection of patients has contributed importantly to the ability to demonstrate benefit from comprehensive geriatric assessment.

In view of the seemingly indispensable role of monitoring and implementation of the care plan in achieving desired outcomes, ongoing health care should be linked systematically to the process of comprehensive geriatric assessment.

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HEALTH CONCERNS AND HEALTH CARE

"Age Page: Safe Use of Medicines by Older People" -- NIA

"Age Page: Safe Use of Tranquilizers" -- NIA

Depression In Older Adults -- St. David's Special Care Program

"Age Page: Who's Who in Health Care" -- NIA

National Institute on Aging

Age Page

Safe Use of Medicines by Older People

Drugs can be wonderful tools for the care of patients of all ages. In fact, the growth of our population over the age of 65 can be attributed at least in part to the availability of effective medicines and vaccines. But in older adults drug use may have greater risks, especially when several drugs are taken at one time.

People over 65 make up 13 percent of the American population, yet they take 30 percent of all prescription drugs sold in this country. As a group, older people tend to have more long-term illnesses—such as arthritis, diabetes, high blood pressure, and heart disease—than younger people. And because they often have a number of diseases or disabilities at the same time, it is very common for them to be taking many different drugs.

In general, drugs taken by older people act differently from the way they do in young or middle-aged people. This is probably the result of the normal changes in body makeup that occur with age. For example, as the body grows older, the percent of water and lean tissue (mainly muscle) decreases, while the percent of fat tissue increases. These changes can affect the time a drug stays in the body and the amount absorbed by body tissues.

The kidneys and the liver are two important organs responsible for breaking down and removing most drugs from the body. With age, these organs begin to function less efficiently, and thus drugs leave the body more slowly. This may account for the fact that older people tend to have more undesirable reactions to drugs than do younger people.

It is important to remember that "drugs" include not only prescription medicines (those ordered by a doctor and dispensed by a pharmacist) but over-the-counter (OTC) medicines as well (those bought and used without a prescription). Drugs prescribed by a doctor are usually more powerful and have more side effects than OTC medicines. Yet many OTC drugs contain strong agents, and when large quantities are taken, they can equal a dose that would normally only be available by prescription.

Some substances, including vitamins, laxatives, cold remedies, antacids, and alcohol, can also lead to serious problems if used too often or in combination with certain other drugs.

There is much that you and your family can do to reduce the risks of drug use. By learning about the drugs you take and their possible side effects, you can help bring about safer and faster treatment results. Some basic rules for safe drug use are as follows:

- Take exactly the amount of drug prescribed by your doctor and follow the dosage schedule as closely as possible. If

you have trouble or questions, call your doctor or pharmacist.

- Medicines will not produce the same effects in all people. Never take drugs prescribed for a friend or relative, even though your symptoms may be the same.
- Always tell your doctor about past problems you have had with drugs (such as rashes, indigestion, dizziness, or lack of appetite). When your doctor prescribes a new drug, be sure to mention *all* other medicines you are currently taking—including those prescribed by another doctor and those you buy without a prescription.
- Keep a daily record of the drugs you are taking, especially if your treatment schedule is complicated or you are taking more than one drug at a time. The record should show the name of the drug, the doctor who prescribed it, the amount you take, and the times of day for taking it. Include a space to check off each dose as you take it. Keep a copy in your medicine cabinet and one in your wallet or pocketbook.
- If child-proof containers are hard for you to handle, ask your pharmacist for easy-to-open containers. Always be sure, however, that they are out of the reach of children.
- Make sure you understand the directions printed on the drug container and that the name of the medicine is clearly printed on the label. Ask your pharmacist to use large type on the label if you find the regular labels hard to read.
- Discard old medicines; many drugs lose their effectiveness over time.
- When you start taking a new drug, ask your doctor or pharmacist about side effects that may occur, about special rules for storage, and about foods or beverages to avoid. Pharmacists are drug specialists and are able to answer most questions about drug use.
- Always call your doctor promptly if you notice unusual reactions.
- New information about drugs and how they affect the older user is coming to light daily. You should occasionally review with your doctor the need for each medicine.

Remember that a chemical agent strong enough to cure an ailment is also strong enough to cause harm if it's not used wisely. Although you should never stop taking medicines without medical advice, if you feel any drug is doing more harm than good, don't be afraid to discuss the matter with your doctor. He or she may be able to substitute another medicine that will be effective.

Other Resources

For more information on the safe use of medicines, contact the Elder Health Program, University of Maryland School of Pharmacy, 20 North Pine Street, Baltimore, MD 21201; and the Food and Drug Administration, Center for Drug Evaluation and Research, Consumer and Professional Affairs (HFD-365), 5600 Fishers Lane, Rockville, MD 20857.

To learn more about health and aging, write to the National Institute on Aging Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057. The NIA distributes free *Age Pages* on a number of topics.

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Safe Use of Tranquilizers

Everyone is worried, tense, or nervous at one time or another. Most people have concerns that can cause them to feel uneasy or anxious, and older people are no exception. Sometimes these feelings of anxiety are accompanied by physical symptoms such as a tightness in the chest, trembling, choking, or rapid heart beat. Since a wide range of problems can produce these feelings, it is very important to have a thorough checkup if your symptoms continue.

There are many ways such symptoms can be managed. Sometimes physical activities or support from family or friends can make a difference. Sometimes professional assistance (individual, group, or family counseling) can be considered. And, sometimes, medications are helpful. "Minor" tranquilizers, or anti-anxiety drugs, recommended by a therapist and prescribed by a doctor, might be used at these times.

Ideally, tranquilizers are used in combination with counseling. The goal is usually to limit the dosage and length of an individual's tranquilizer use. This is especially important for older people because age-related changes often cause the body to react to medications differently in later life. As a result, older people should pay close attention to side effects and safety considerations when taking tranquilizers.

Effects of Tranquilizers

Tranquilizers are central nervous system (CNS) depressants. That is, they slow down the nervous system and can cause drowsiness. Some individuals, particularly older people, may become sleepy, dizzy, unsteady on their feet, and confused when taking these drugs. If the medication is taken at night, these side effects may occur the next day. As a result, when taking tranquilizers you should not drive, operate machinery, or do jobs that require you to be alert.

The effects of tranquilizers are greatly increased if they are taken at the same time as other CNS depressants such as antihistamines (medicines for allergies or colds), sleeping pills, prescription pain relievers, or muscle relaxants. It is also important to avoid alcohol when taking tranquilizers because it too is a powerful CNS depressant. Mixing large amounts of drugs and alcohol can cause unconsciousness and even death.

Some medicines, such as the ulcer drug cimetidine, may affect the body's use of tranquilizers. A doctor or pharmacist can tell you which medicines are safe to take with tranquilizers. Always tell the doctor what prescription and over-the-counter medications you are taking whenever he or she is considering a new medication for you.

Once you begin taking a tranquilizer, do not stop taking it suddenly. This can cause withdrawal symptoms including convulsions, muscle cramps, sweating, and vomiting. When it is time to stop your medication, the doctor will probably reduce the dose slowly to prevent these symptoms.

Sometimes people taking tranquilizers are afraid they will not be able to handle their problems without the medication. They may insist that their doctors prescribe tranquilizers for a longer period of time than is recommended. Since people who take tranquilizers for a long period of time may become dependent on them, it is very important to take this medication only under the careful supervision of a doctor.

Taking Tranquilizers Safely

When taking a tranquilizer you should observe the following safety tips:

- Make sure the doctor knows about all your current medications (both prescription and over-the-counter) before you begin taking tranquilizers.
- Ask the doctor to explain any possible side effects of the tranquilizer he or she has prescribed.
- Follow the doctor's instructions exactly.
- Take only the amount of tranquilizer the doctor specifies—no more, no less.
- Take the tranquilizer only as often as prescribed—not more or less frequently.
- If you forget one dose of the medicine, do not double the next dose.
- Let the doctor know if you experience excessive drowsiness or other side effects—sometimes a shorter acting tranquilizer can relieve those complaints.
- Let the doctor know if you feel unusually chilly while taking tranquilizers. Sometimes they can cause a change in body temperature.
- Try to avoid caffeine (found in coffee, tea, cola drinks, and chocolate) while taking tranquilizers—it can counteract the effects of the tranquilizer.
- If you think you may have taken too many tranquilizers, get emergency help right away.

For More Information

Tranquilizers can help many people manage the symptoms of anxiety. However, for these medicines to work safely and effectively, they must be taken as directed. Learning more about the medications the doctor prescribes will increase your health, safety, and well-being. For more information on the safe use of medications, contact the following organizations.

The Elder Health Program provides patient information and service programs for older people. Write to the University of Maryland School of Pharmacy, 20 North Pine Street, Baltimore, MD 21201.

The American Association of Retired Persons' Pharmacy Service provides prescription drug information for their members. Write to the AARP at 1909 K Street, NW., Washington, DC 20049.

The Food and Drug Administration provides information about drugs and their side effects. Write to the Center for Drug Evaluation and Research, Consumer and Professional Affairs (HFD-365), 5600 Fishers Lane, Rockville, MD 20857.

The National Institute on Aging provides information about health and aging. Write to the NIA Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service National Institutes of Health

This information provided as a public service by The Pavilion at St. David's Special Care Program for Older Adults. For further information call: 1 (800) 421-1620.

DEPRESSION IN OLDER ADULTS

Depression is a significant problem for adults over 65. Some researchers say that about 1/3 of those over 65 will experience depression. Depressed older adults have the highest risk of suicide of any group in our society. Depression is treatable and is most often resolved with proper care. Often, however, older adults with depression go untreated. Sometimes it is a matter of their not seeking treatment. Sometimes they are not treated because the depression is not recognized by family, friends or professionals. Some of the basic symptoms are:

- insomnia or too much sleep
- crying spells
- low, sad mood
- poor appetite or over eating
- disregard for personal appearance
- sad or blank look on the face
- thoughts of suicide

Depression is probably the most common cause of forgetfulness, confusion and disorientation in older adults. It may be confused with physical problems called dementias that involve brain disorders. The following chart can be helpful in distinguishing between Depression and Dementia.

Depression

1. symptoms are of short duration
2. person complains of loss of memory and thinking ability
3. person feels a lot of distress
4. person forgets recent *and* past events
5. person answers questions with "I don't know"
6. person emphasizes disability
7. person makes little effort to perform even simple tasks
8. person highlights failures
9. person does not try to keep up with dates and activities
10. general decline in appearance - the person "looks" depressed
11. person loses interest in social work
12. symptoms do not get worse at night

Dementia (Alzheimer's Disease, Multiple Strokes or Other)

1. symptoms are of long duration
2. person seldom complains of loss of memory and thinking ability
3. person appears unconcerned
4. person remembers past events more than recent events
5. person answers questions incorrectly
6. person conceals disability
7. person struggles to perform simple tasks
8. person delights in accomplishments
9. persons relies on notes, calendars, etc. to keep up
10. appearance fluctuates from day to day social skills
11. person often retaines social skills
12. symptoms may appear to worsen at night

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A professional should determine if depression is present. Patients who have a dementia may be depressed too; their depression can also be treated.

Facts About Depression in Older Adults:

1. Many physical illnesses such as a stroke or Parkinson's Disease may cause symptoms of depression.
2. Physical illnesses may cause older persons to be depressed because they fear pain, disability or losing their independence.
3. Older adults who are depressed may complain of bodily aches and pains without appearing to have a low, sad mood.
4. Drugs such as heart pills, tranquilizers and blood pressure medications can cause signs of depression.
5. Depression may be caused by or made worse by the person being lonely or isolated from others.
6. Older adults who do not obtain good health care or who do not participate in recreational activities may be depressed.
7. Persons who experience significant losses such as the death of a spouse or having to enter a nursing home may become depressed.

It is important to know that depression, *can* be recognized and treated with good results. Be sure to contact your physician for a proper diagnosis. Discuss with the doctor the causes of the depression and how it can best be treated. It is tragic that many patients' symptoms go unrecognized, therefore untreated.

National Institute on Aging

Age Page

Who's Who in Health Care

In many cases, the family doctor is no longer the sole provider of medical care and advice for older Americans. Older people are treated not only by doctors and nurses, but by technicians, medical assistants, and therapists. With this variety of health providers, it is important to understand which professionals can offer the best and least costly care for a specific problem and which services normally will be paid by Medicare.

The following definitions cover some, but not all, of the medical practitioners frequently seen by older people.

Doctors of medicine (M.D.) use all accepted methods of medical care. They treat diseases and injuries, provide preventive care, do routine checkups, prescribe drugs, and do some surgery. M.D.'s complete medical school plus 3 to 7 years of graduate medical education. They must be licensed by the state in which they practice.

Doctors of osteopathic medicine (D.O.) provide general health care to individuals and families. The training osteopaths receive is similar to that of an M.D. In addition to treating patients with drugs, surgery, and other treatments, a D.O. may emphasize movement in treating problems of muscles, bones, and joints.

Family practitioners are M.D.'s or D.O.'s who specialize in providing comprehensive, continuous health care for all family members, regardless of age or sex.

Geriatricians are physicians with special training in the diagnosis, treatment, and prevention of disorders in older people. Geriatric medicine recognizes aging as a normal process, not a disease state.

Internists (M.D. or D.O.) specialize in the diagnosis and medical treatment of diseases in adults. Internists do not deliver babies.

Surgeons treat diseases, injuries, and deformities by operating on the body. A general surgeon is qualified to perform many common operations, but many specialize in one area of the body. For example, neurosurgeons treat disorders relating to the nervous system, spinal cord, and brain; orthopedic surgeons treat disorders of the bones, joints, muscles, ligaments, and tendons; and thoracic surgeons treat disorders to the chest.

The above physicians may refer patients to the following specialists:

- Cardiologist—a heart specialist
- Dermatologist—a skin specialist
- Endocrinologist—a specialist in disorders of the glands of internal secretion, such as diabetes
- Gastroenterologist—a specialist in diseases of the digestive tract
- Gynecologist—a specialist in the female reproductive system
- Hematologist—a specialist in disorders of the blood
- Nephrologist—a specialist in the function and diseases of the kidneys

- Neurologist—a specialist in disorders of the nervous system
- Oncologist—a specialist in cancer
- Ophthalmologist—an eye specialist
- Otolaryngologist—a specialist in diseases of the ear, nose, and throat
- Physiatrist—a specialist in physical medicine and rehabilitation
- Psychiatrist—a specialist in mental, emotional, and behavioral disorders
- Pulmonary specialist—a physician who treats disorders of the lungs and chest
- Rheumatologist—a specialist in arthritis and rheumatism
- Urologist—a specialist in the urinary system in both sexes and the male reproductive system.

Most of the services of M.D.'s and D.O.'s are covered by Medicare.

Dental Care

Dentists (D.D.S. or D.M.D.) treat oral conditions such as gum disease and tooth decay. They give regular checkups and routine dental and preventive care, fill cavities, remove teeth, provide dentures, and check for cancers in the mouth. Dentists can prescribe medication and perform oral surgery. A general dentist might refer patients to a specialist such as an **oral surgeon**, who does difficult tooth removals and surgery on the jaw; an **endodontist**, who is an expert on root canals; a **periodontist**, who is knowledgeable about gum diseases; or a dentist who specializes in geriatrics. Medicare will not pay for any dental care except for surgery on the jaw or facial bones.

Eye Care

Ophthalmologists (M.D. or D.O.) specialize in the diagnosis and treatment of eye diseases. They also prescribe eyeglasses and contact lenses. Ophthalmologists can prescribe drugs and perform surgery. They often treat older people who have glaucoma and cataracts. Medicare helps pay for all medically necessary surgery or treatment of eye diseases and for exams and eyeglasses to correct vision after cataract surgery. But it will not pay for a routine exam, eyeglasses, or contact lenses.

Optometrists (O.D.) generally have a bachelor's degree plus 4 years of graduate training in a school of optometry. They are trained to diagnose eye abnormalities and prescribe, supply, and adjust eyeglasses and contact lenses. In most states optometrists can use drugs to diagnose eye disorders. An optometrist may refer patients to an ophthalmologist or other medical specialist in cases requiring medication or surgery. Medicare pays for only a limited number of optometric services.

Opticians fit, supply, and adjust eyeglasses and contact lenses which have been prescribed by an ophthalmologist or optometrist. They cannot examine or test the eyes, or prescribe glasses or drugs. Opticians are licensed in 22 states and may have formal training. Traditionally, most opticians are trained on the job.

Mental Health Care

Psychiatrists (M.D. or D.O.) treat people with mental and emotional difficulties. They can prescribe medication and counsel patients, as well as perform diagnostic tests to determine if there are physical problems. Medicare will pay for a portion of both inpatient and outpatient psychiatric costs.

Psychologists (Ph.D., Psy.D., Ed.D., or M.A.) are health care professionals trained and licensed to assess, diagnose, and treat people with mental, emotional, or behavioral disorders. Psychologists counsel people through individual, group, or family therapy. Medicare will pay for a portion of psychologists' counseling services when performed in connection with the services of a psychiatrist or other physican.

Nursing Care

Registered nurses (R.N.) may have 2, 3, or 4 years of education in a nursing school. In addition to giving medicine, administering treatments, and educating patients, R.N.'s also work in doctors' offices, clinics, and community health agencies. Medicare does not cover private duty nursing. It helps pay for general nursing services by reimbursing hospitals, skilled nursing facilities, and home health agencies for part of the nurses' salaries.

Nurse practitioners (R.N. or N.P.) are registered nurses with training beyond basic nursing education. They perform physical examinations and diagnostic tests, counsel patients, and develop treatment programs. Nurse practitioners may work independently, such as in rural clinics, or may be staff members at hospitals and other health facilities. They are educated in a number of specialties, including gerontological nursing. Medicare will help pay for services performed under the supervision of a doctor.

Licensed practical nurses (L.P.N.) have from 12 to 18 months of training and are most frequently found in hospitals and long-term care facilities where they provide much of the routine patient care. They also assist physicians and registered nurses.

Rehabilitative Care

Occupational therapists (O.T.) assist those whose ability to function has been impaired by accident, illness, or other disability. They increase or restore independence in feeding, bathing, dressing, homemaking, and social experiences through specialized activities designed to improve function. Occupational therapy services are paid by Medicare if the patient is in a hospital or a skilled nursing facility or is receiving home health care. Coverage is also available for services provided in physicians' offices or to hospital outpatients. O.T.'s have either a bachelor's or master's degree with special training in occupational therapy.

Physical therapists (P.T.) help people whose strength, ability to move, or sensation is impaired. They may use exercise; heat, cold, or water therapy; or other treatments to control pain, strengthen muscles, and improve coordination. All P.T.'s complete a bachelor's degree and some receive further postgraduate training. Patients are usually referred to a physical therapist by a doctor, and Medicare pays some of the costs of outpatient treatments. Physical therapy performed in a hospital or skilled nursing facility is covered by Medicare.

Speech-language pathologists are concerned with speech and language problems. **Audiologists** are concerned with hearing disorders. Both specialists test and evaluate patients and provide treatment to restore as much normal function as possible. Many speech-language pathologists work with stroke victims, people who have had their vocal cords removed, or those who have developmental speech and language disorders. Audiologists work with people who have difficulty hearing. They recommend and sometimes dispense hearing aids. Speech-language pathologists and audiologists have at least a master's degree. Most are licensed by the state in which they practice. Medicare generally will cover the diagnostic services of speech-language pathologists and audiologists; it will not cover routine hearing evaluations or hearing aid services.

General Care

Pharmacists are knowledgeable about the chemical makeup and correct use of medicines—the names, ingredients, side effects, and uses in the treatment of medical problems. Pharmacists have legal authority to dispense drugs according to formal instructions issued by physicians, dentists, or podiatrists. They also can provide information on nonprescription products sold in pharmacies. Pharmacists must complete 5 or 6 years of college, fulfill a practical experience

requirement, and pass a state licensing examination to practice.

Physician assistants (P.A.) usually work in hospitals or doctor's offices and do some of the tasks traditionally performed by doctors, such as taking medical histories and doing physical examinations. Education for a P.A. includes 2 to 4 years of college followed by a 2-year period of specialized training. P.A.'s must always be under the supervision of a doctor. Medicare will pay for the services provided by a P.A. only if they are performed in a hospital or doctor's office under the supervision of a physician.

Podiatrists (D.P.M.) diagnose, treat, and prevent diseases and injuries of the foot. They may do surgery, make devices to correct or prevent foot problems, provide toenail care, and prescribe certain drugs. A podiatrist completes 4 years of professional school and is licensed. Medicare will cover the cost of their services except routine foot care. (However, routine foot care is covered if it is necessary because of diabetic complications.)

Registered dietitians (R.D.) provide nutrition care services and dietary counseling in health and disease. Most work in hospitals, public health agencies, or doctors' offices, but some are in private practice. R.D.'s complete a bachelor's or a graduate degree with a program in dietetics/nutrition and complete an approved program in dietetic practice such as an internship. Medicare generally will not pay for dietitian services; however, it does reimburse hospitals and skilled nursing facilities for a portion of dietitian's salaries.

"Nutritionist" is a broad term. Currently, practitioners who wish to call themselves nutritionists need not fulfill a licensing or certification requirement. The title may be used by a wide range of people, including R.D.'s, those who take a correspondence or other short-term course in nutrition, or even people who are self-taught. Before seeking the advice of a health practitioner in nutrition, it is a good idea to ask what kind of training and practical experience the person has received.

Social workers in health care settings go after community services for patients, provide counseling when necessary, and help patients and their families handle problems related to physical and mental illness and disability. They frequently coordinate the multiple aspects of care related to illness, including discharge planning from hospitals. A social worker's education ranges from a bachelor's degree to a doctorate. Most have a master's degree (M.S.W.). Medicare covers services provided by social workers if they work in such settings as hospitals, home health care agencies, hospices, and health maintenance organizations.

These and other health professionals are especially important to older adults, some of whom require a great deal of medical attention. Ideally, all health professionals will work together to provide older people with care that is comprehensive, cost-effective, and compassionate.

For additional resources on health and aging, write to the National Institute on Aging Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057.

1991

UNDERSTANDING COMMUNITY SERVICES

Locating Sources of Information Regarding Aging Services -- N. Wilson

Checklist for Interviewing Agencies -- S. Luk

Service Definitions -- U.S. Congress, Office of Technology Assessment

Planning for the Long-Term Support/Care System: The Array of Services to be Considered -- S. Brody, Health Services Council, PA

The National Eldercare Campaign -- Perspectives in Health Promotion and Aging

Background on the Aging Network in Texas

LOCATING SOURCES OF INFORMATION REGARDING AGING SERVICES

In order to effectively assist older people and their family members, one must have a working knowledge of available community services and sources of help. Each community is unique and the organization of health and social services varies from an extensive array of coordinated services to a limited selection of helping services. The following guidelines are suggestions about where you might want to locate information to assist you in understanding services available to your clients. If you want to become the local expert on services consider making contact with the following potential sources of information:

1. **Information and Referral Services (I & R):** In most communities there is at least one and often a number of information and referral services designed to inform the elderly and their families of the great variety of services available to them. Many I&R services also maintain resource directories or reference files including information such as the type of assistance available, eligibility requirements, and personnel involved. In order to locate information and referral agencies one should consider contacting the following places:

    a. the local Area Agency on Aging;
    b. the local telephone directory;
    c. the local United Way Agency;
    d. local family service, mental health or other social service agency.

2. **Case Management Services:** Other potential sources of information on community services are those agencies or programs which provide case management. Case or care management programs coordinate services on behalf of clients with multiple needs. This generally includes assessing a client's needs, developing a care plan and providing problem solving and follow-up assistance over time. To identify local case management programs you could contact the same sources noted in #1 above. Persons working as case managers are likely to have extensive knowledge of community services.

3. **Hospital or Home Care Social Workers:** Social workers who work in the hospital or with a home care agency are often responsible for discharge planning or other social service assistance for older individuals who have functional limitations. They may have more extensive information about assistance available for persons with specific health or mental health needs. For example, a medical social worker might be familiar with home care services, medical equipment, and residential care facilities.

4. **Public Agencies:** Especially in rural communities the State and County agencies responsible for health and human services may be one of the few agencies located in the area instead of in a nearby metropolitan area. In addition to providing information about community care, Medicaid and other financial entitlements, and nursing homes, the Texas Department of Human Services staff may be key contacts about other available community services.

5. **Specialized Voluntary Agencies:** Many non-profit associations are dedicated to helping individuals and families affected by a particular disease such as Cancer, Alzheimer's Disease. In addition to distributing educational materials about specific disorders many of these organizations maintain extensive information about resources and services available for special populations such as persons with arthritis, etc..

Prepared by Nancy L. Wilson

Prepared by Susanna Luk and Nancy L. Wilson

CHECKLIST FOR INTERVIEWING AGENCIES

The following outline will help someone seeking to learn about a community agency.

I. **Agency Information**
   - A. Name
   - B. Address
   - C. Telephone Number
   - D. Contact Person
   - E. Days/ Hours of Operation

II. **Auspice**
   - A. Is the agency a private or public organization?
   - B. Is the agency non-profit or for profit?
   - C. Is the agency free-standing or part of a larger network or structure ?

III. **Mission Statement**
   - A. What is the agency's primary focus?
   - B. What target populations does this agency exist to serve ?

IV. **Service Delivery**
   - A. List the services offered by the organization and where they are provided.
   - B. Describe what each service entails.
   - C. What is the background of the staff involved in service delivery ?

V. **Eligibility Criteria for Services**
   - A. Age criteria
   - B. Income requirements
   - C. Citizenship status
   - D. Geographic residence
   - E. Health/functional status
   - F. Language/ Communication skills
   - G. Other criteria

VI. **Financing of Programs and Services**
   - A. Grants (public and/or private foundation)
   - B. Donations
   - C. Client fee/out of pocket expense
   - D. Medicare/Medicaid

E. Private insurance
F. Third party reimbursement

VII. Central Issues for the Agency

A. Issues affecting service delivery.
B. Financial issues
C. Staffing issues
D. Agency Priorities

VIII. Future Trends

A. What are the trends affecting the target population?
B. What are the trends in service delivery?
C. What trends are influencing the internal structure of the agency?

Physician services: Diagnosis and ongoing medical care, including prescribing medications and treating intercurrent illness.

Patient assessment: Evaluation of the individual's physical, mental, and emotional status, behavior, and social supports.

Skilled nursing: Medically oriented care provided by a licensed nurse, including monitoring acute and unstable medical conditions; assessing care needs; supervising medications, tube and intravenous feeding, and personal care services; and treating bed sores and other conditions.

Physical therapy: Rehabilitative treatment provided by a physical therapist.

Occupational therapy: Treatment to improve functional abilities; provided by an occupational therapist.

Speech therapy: Treatment to improve or restore speech; provided by a speech therapist.

Personal care: Assistance with basic self-care activities such as bathing, dressing, getting out of bed, eating, and using the bathroom.

Home health aide services: Assistance with health-related tasks, such as medications, exercises, and personal care.

Homemaker services: Household services, such as cooking, cleaning, laundry, and shopping, and escort service to accompany patients to medical appointments and elsewhere.

Chore services: Household repairs, yard work, and errands.

Supervision: Monitoring an individual's whereabouts to ensure his or her safety.

Paid companion/sitter: An individual who comes to the home to provide supervision, personal care, and socialization during the absence of the primary caregiver.

Congregate meals: Meals provided in a group setting for people who may benefit both from the nutritionally sound meal and from social, educational, and recreational services provided at the setting.

Home-delivered meals: Meals delivered to the home for individuals who are unable to shop or cook for themselves.

Telephone reassurance: Regular telephone calls to individuals who are isolated and often homebound.

Personal emergency response systems: Telephone-based systems to alert others that an individual who is alone is experiencing an emergency and needs assistance.

Transportation: Transporting people to medical appointments, community facilities, and elsewhere.

Recreational services: Physical exercise, art and music therapy, parties, celebrations, and other social and recreational activites.

Mental health services: Psychosocial assessment and individual and group counseling to address psychological and emotional problems of patients and families.

Adult day care: A program of medical and social services, including socialization, activities, and supervision, provided in an outpatient setting.

Respite care: Short-term, in- or out-patient services intended to provide temporary relief for the primary caregiver.

Dental services: Care of the teeth, and diagnosis and treatment of dental problems.

Legal services: Assistance with legal matters, such as advance directives, guardianship, power of attorney, and transfer of assets.

Protective services: Social and law enforcement services to prevent, eliminate, or remedy the effects of physical and emotional abuse or neglect.

Case management: Client assessment, identification and coordination of community resources, and followup monitoring of client adjustment and service provision.

Information and referral: Provision of written or verbal information about community agencies, services, and funding sources.

Hospice services: Medical, nursing, and social services to provide support and alleviate suffering for dying persons and their families.

Source: Office of Technology Assessment, Losing a Million

BEST COPY AVAILABLE

Reference: Brody,S.J. Planning for the Long-Term Support/ Care System: The Array of Services To Be Considered. Health Services Council, Philadelphia, 1979

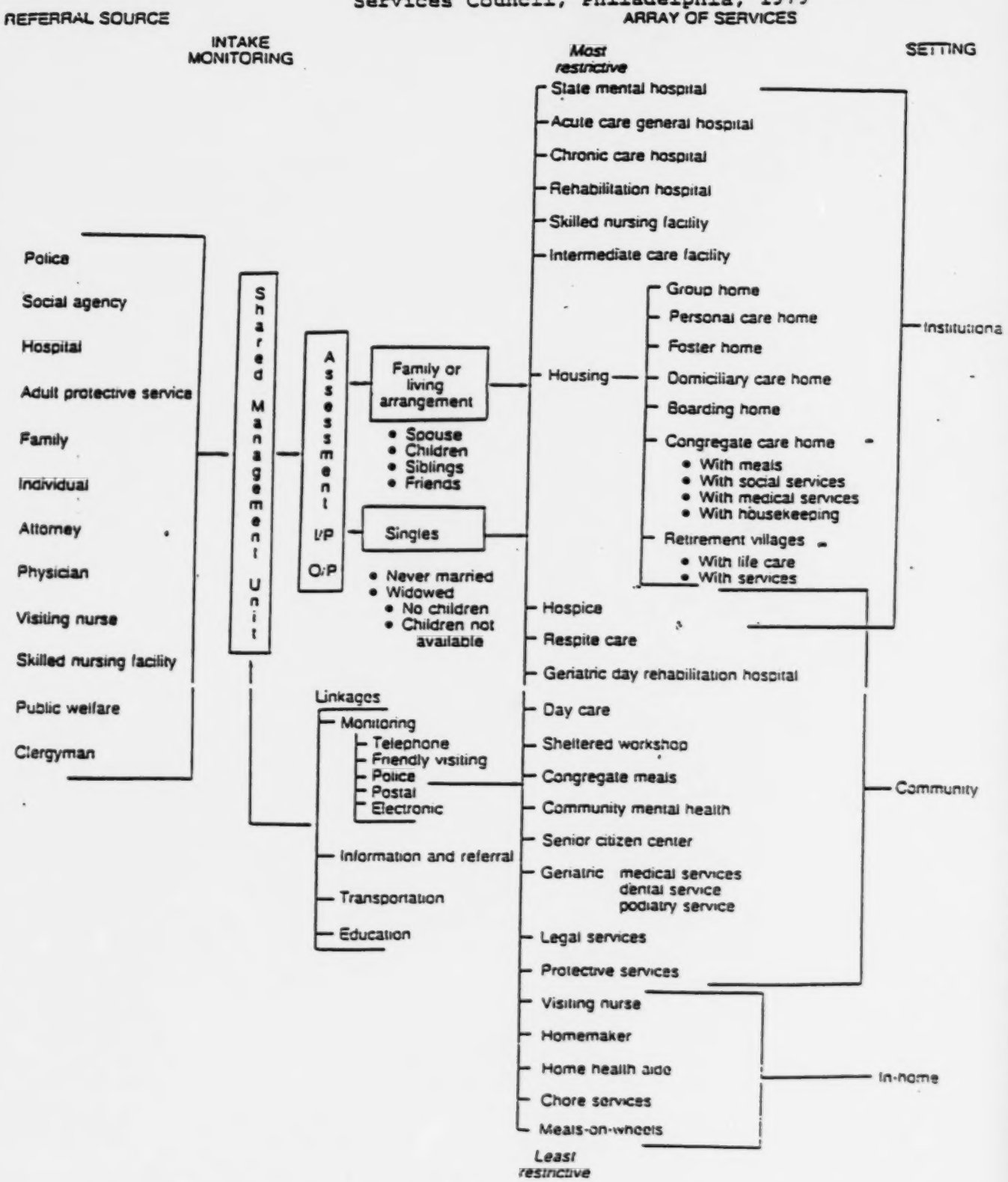

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FIG. 1. Long-term support system: a paradigm. I/P, O-P = inpatient, outpatient. The classification of from most to least restrictive is a general view of services and may vary within each service. (From ref. 3.)

Current Issues

Perspectives in Health Promotion and Aging, vol.7, no.1, 1992

The twelve Eldercare Institutes established include:

National Eldercare Institute on Health Promotion

National Eldercare Institute on Long Term Care

National Eldercare Institute on Elder Abuse and State Long Term Care Ombudsman Services

National Eldercare Institute on Older Women

National Eldercare Institute on Multipurpose Senior Centers and Community Focal Points

National Eldercare Institute on Transportation

National Eldercare Institute on Housing and Supportive Services

National Eldercare Institute on Nutrition

National Eldercare Institute on Human Resource Development

National Eldercare Institute on Income Security

National Eldercare Institute on Employment and Volunteerism

National Eldercare Institute on Business and Aging

See the insert for a description of the new National Eldercare Institute on Health Promotion located at the American Association of Retired Persons.

The National Eldercare Campaign

The National Eldercare Campaign, announced early in 1991 by U.S. Commissioner on Aging, Joyce Berry, Ph.D. (see guest column) is an innovative, multifaceted approach for making all sectors of our society aware of the implications of aging and the commitments that must be made by public, private, and voluntary organizations to assure the availability of home and community-based services. The national campaign is a multiyear effort to motivate a wide spectrum of individuals, agencies, and organizations to take action on behalf of older persons at risk of losing their self-sufficiency. The active participation of individuals representing government, business and labor, educational and religious organizations, civic and other voluntary associations holds great potential for promoting independence for older persons across the nation.

The Administration on Aging is encouraging organizations and individuals to take part in the National Eldercare Campaign, which has three specific goals:

- alert the public to the need for individual and collective action to address the unmet needs of today's older persons and to prepare for the challenge of a society that must soon meet the needs of a significantly larger number of older people;
- broaden the base of existing public and private involvement and support to address the need for in-home and community-based services for older persons at risk now and in the future; and,
- encourage communities across the nation to use the full range of public and private resources available to them to respond to the needs of older persons at risk of losing their independence.

The campaign will achieve its goals by:

- focusing the attention of the general public, corporations an other private, public, and voluntary organizations on eldercare and issues related to the unmet need for services by older persons who are at risk.
- involving a wide range of agencies and organizations, representing government, business, labor, voluntary, religious and civic groups, to provide guidance and assistance to local affiliates to address the unmet service needs of older persons at risk in communities nationwide.

One major component of the National Eldercare Campaign that seeks to broaden the base of involvement and commitment to the nation's elderly, is Project CARE (Community Action to Reach the Elderly). Project CARE empowers communities to take action to increase the resources and services available to community members at risk of losing their self-sufficiency. The project builds a community coalition that brings together a broad range of resources to build a spirit of caring in the community and to tap the expertise, energy and experience of the community-at-large, including organizations without a predominant focus on aging. Each of the more than 250 Project CARE communities, started in 1991, is identifying a problem of primary importance to the vulnerable elderly in their community, and developing and implementing a plan of action to address the problem. The long-term goal is to have the Project CARE concept implemented in communities across the nation.

AoA has made grants to State Agencies on Aging to stimulate the development of the Project CARE community coalitions. In addition, AoA has provided financial assistance to a number of national organizations to assist in the implementation of special projects for addressing eldercare needs. Twelve National Eldercare Institutes were established through a cooperative agreement to focus on critical substantive areas closely related to the delivery of eldercare services; they will serve as a knowledge base and program resources, to promote the effective transfer, dissemination and utilization of relevant information, and to provide training and technical assistance. The Institutes will work with community coalitions to support their efforts to develop and implement in home and community-based eldercare services. The Institutes also will work with national aging and other organizations in the public, private, and voluntary sectors to further the goals of the National Eldercare Campaign.

BACKGROUND ON THE AGING NETWORK IN TEXAS

The Texas Department of Aging (TDoA) is the only state agency whose sole responsibility is serving older Texans. About 85 percent of TDoA's funding comes from the federal government through the Older Americans Act. The rest comes from state appropriations and local matching funds. The department provides a wide array of services (which vary according to local needs and resources) to any Texan 60 or older.

The Texas Department of Aging offers services chiefly through its 28 area agencies on aging (AAAs). Every three years, these area agencies hold public hearings throughout the state to give the public a chance to describe the needs of seniors in their areas. The following pages include the listings of all Area Agencies on Aging in Texas and the counties served by each AAA.

For information about services for older Texans, or for copies of this brochure about TDoA contact:
Texas Department on Aging, P. O. Box 12786, Capitol Station, Austin, TX 78711
(512) 444-2727 or 1-800-252-9240 (Toll Free)

TEXAS AAA NETWORK

Alamo Area Agency on Aging
Frank Adamo, Director
118 Broadway, Suite 400
San Antonio, Texas 78205
(210) 225-5201
FAX #: (210) 225-5937
(Serves Atascosa, Bandera, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, and Wilson Counties)

Ark-Tex Area Agency on Aging
Maratha Smith, Manager
P. O. Box 5307
Texarkana, Texas 75505
911 North Bishop Road
Wake Village, Texas 75501
(903) 832-8636
FAX #: (903) 832-3441
(Serves Bowie, Cass, Delta, Franklin, Hopkins, Lamar, Morris, Red River, and Titus Counties)

Bexar County Area Agency on Aging
Minnie Williams, Director
118 Broadway, Suite 400
San Antonio, Texas 78205
(210) 225-5201
FAX #: (210) 225-5937
(Serves Bexar County)

Brazos Valley Area Agency on Aging
Roberta Lindquist, Director
3006 E. 29th St. (77802)
P. O. Drawer 4128
Bryan, Texas 77805-4128
(409) 776-2277
Fax #: (409) 776-2280
(Serves Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington Counties)

Capital Area Agency on Aging
Delma Juarez, Manager
2520 South IH 35, Suite 100
Austin, Texas 78704
(512) 443-7653
FAX #: (512) 443-7658
(Serves Bastrop, Burnett, Blanco, Caldwell, Fayette, Hays, Lee, Llano, Travis, and Williamson Counties)

Central Texas Area Agency on Aging
H. Richard McGhee, Director
302 E. Central
P. O. Box 729
Belton, Texas 76513
(817) 939-1886 & (800) 447-7169
FAX #: (817) 933-7521
(Serves Bell, Coryell, Hamilton, Lampasas, Milam, Mills, and San Saba Counties)

Coastal Bend Area Agency on Aging
Betty Lamb, Director
P. O. Box 9909
Corpus Christi, Texas 78469
(512) 883-5743
FAX #: (512) 883-5749
(Serves Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, and San Patricio Counties)

Concho Valley Area Agency on Aging
Betty Ford, Director
P. O. Box 60050
San Angelo, Texas 76906
(915) 944-9666
FAX #: (915) 944-9925
(Serves Coke, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Reagan, Schleicher, Sterling, Sutton, and Tom Green Counties)

revised 4/30/93

Dallas County Area Agency on Aging
Norman Moorehead, Director
2121 Main Street, Suite 500
Dallas, Texas 75201-4321
(214) 741-5851
FAX #: (214) 748-6051
(Serves Dallas County)

Deep-East Texas Area Agency on Aging
Holly Anderson, Director
274 E. Lamar
Jasper, Texas 75951
(409) 384-9085 & (800) 256-7277
FAX #: (409) 384-5390
(Serves Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler Counties)

East Texas Area Agency on Aging
Claude Andrews, Director
3800 Stone Road
Kilgore, Texas 75662
(903) 984-8641 & (800) 442-8845
FAX #: (903) 983-1440
(Serves Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, Upshur, Van Zandt, and Wood Counties)

Golden Crescent Area Agency on Aging
Cindy Cornish, Director
Victoria Reg. Airport Bldg. #102
P. O. Box 2028
Victoria, Texas 77902
(512) 578-1587
FAX #: (512) 578-8865
(Serves Calhoun, DeWitt, Golaid, Gonzales, Jackson, Lavaca, and Victoria Counties)

Harris County Area Agency on Aging
Charlene Hunter James, Chief
Office on Aging
Business Management, 7th Floor
8000 North Stadium Dr.
Houston, Texas 77054
(713) 794-9001
FAX #: (713) 794-9464
(Serves Harris County)

Heart of Texas Area Agency on Aging
John W. McCue, Sr., Director
300 Franklin Avenue
Waco, Texas 76701
(817) 756-7822
FAX #: (817) 756-0102
(Serves Bosque, Falls, Freestone, Hill, Limestone, and McLennan Counties)

Houston-Galveston Area Agency on Aging
Donald R. Smith,
Aging Programs Manager
3555 Timmons Lane, Suite 500
(77027)
P. O. Box 22777
Houston, Texas 77227
(713) 627-3200 & (800) 437-7396
FAX #: (713) 621-8129
(Serves Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton Counties)

Lower Rio Grande Valley Area Agency on Aging
Joe Gonzalez, Director
4900 N. 23rd
McAllen, Texas 78504
(210) 682-3481 & (800) 365-6131
FAX #: (210) 631-4670
(Serves Cameron, Hidalgo, and Willacy Counties)

Middle Rio Grande Valley Area Agency on Aging
Martha Duerksen, Director
1904 North First Street
P. O. Box 1199
Carrizo Springs, Texas 78834
(210) 876-3533
FAX #: (210) 876-9415
(Serves Dimmit, Edwards, Kinney, LaSalle, Maverick, Real, Uvalde, Val Verde, and Zavala Counties)

North Central Texas Area Agency on Aging
Nelda Davis, Manager of Aging Programs
616 Six Flags Drive
P. O. Box 5888
Arlington, Texas 76005-5888
(817) 640-3300 & (800) 272-3921
FAX #: (817) 640-7806
(Serves Collin, Denton, Ellis, Erath, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, and Wise Counties)

North Texas Area Agency on Aging
Rhonda Poque, Director
4309 Jacksboro Highway (76302)
P. O. Box 5144
Wichita Falls, Texas 76307
(817) 322-5281
FAX #: (817) 322-6743
(serves Archer, Baylor, Clay, Cottle, Foard, Hardeman, Jack, Montague, Wichita, Wilbarger, and Young Counties)

Panhandle Area Agency on Aging
M. K. McQueen, Director
415 West 8th
P. O. Box 9257
Amarillo, Texas 79105-9257
(806) 372-3381 & (800) 642-6008
FAX #: (806) 373-3268
(Serves Armstrong, Brisco, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Orchiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, and Wheeler Counties)

Permian Basin Area Agency on Aging
W. E. Smith, Director
2910 LaForce Blvd. (79711)
P. O. Box 60660
Midland, Texas 79711
(915) 563-1061
FAX #: (915) 563-1728
(Serves Andrews, Borden, Crane, Dawson, Ector, Gaines, Glasscock, Howard, Loving, Martin, Midland, Pecos, Reeves, Terrell, Upton, Ward, and Winkler Counties)

Rio Grande Area Agency on Aging
Andrea Carrillo, Director
1100 N. Stanton, Suite 610
El Paso, Texas 79902
(915) 533-0998 & (800) 333-7082
FAX #: (915) 532-9385
(Serves Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, and Presidio Counties)

South East Texas Area Agency on Aging
Joyce Philen, Director
3501 Turtle Creek Dr., Suite 108
(Port Arthur 77642
P. O. Drawer 1387
Nederland, Texas 77627
(409) 721-5465 & (800) 395-5465
FAX #: (409) 727-4078
(Serves Hardin, Jefferson, and Orange Counties)

South Plains Area Agency on Aging
Robert Marshall, Director
1323 58th Street (79452)
P. O. Box 3730
Freedom Station
Lubbock, Texas 79452
(806) 762-8721 & (800) 858-1809
FAX #: (806) 765-9544
(Serves Bailey, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, King, Lamb, Lubbock, Lynn, Motley, Terry, and Yoakum Counties)

South Texas Area Agency on Aging
Andy Smith, Aging Services Director
600 S. Sandman (78041)
P. O. Box 2187
Laredo, Texas 78044-2187
(210) 722-3995 & (800) 292-5426
FAX #: (210) 722-2670
(Serves Jim Hogg, Starr, Webb, and Zapata Counties)

Tarrant County Area Agency on Aging
Patricia F. Cheong, Director
210 East Ninth Street
Fort Worth, Texas 76102
(817) 878-0081
FAX #: (817) 878-0005

Texoma Area Agency on Aging
Janis Gray, Director
10,000 Grayson Drive
Denison, Texas 75020
(903) 786-2955
FAX #: (903) 786-8122
(Serves Cooke, Fannin, and Grayson Counties)

West Central Texas Area Agency on Aging
Dr. Lewis Lemmond, Director
1025 E. North 10th St.
P. O. Box 3195
Abilene, Texas 79604
(915) 672-8544
FAX #: (915) 675-5214
(Serves Brown, Callahan, Coleman, Comanche, Eastland, Fisher, Haskell, Jones, Kent, Knox, Mitchell, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, and Throckmorton Counties)

LINKING CLIENTS TO SERVICES

Linking Clients to the Appropriate Services -- B. Sheafor, et. al.

Texas Department of Human Services Community Care for Aged and Disabled -- TDHS

Toll-Free Numbers in Texas

Sources of Informal Services -- A. S. Barusch

Adapted from Techniques and Guidelines for Social Work Practice by Bradford W. Sheafer, Charles R. Horejsi, and Gloria A. Horejsi.

LINKING CLIENTS TO THE APPROPRIATE SERVICES

An important activity of social work consists of linking clients with the community resources and services appropriate to the individual client's needs.

Steps to identifying the appropriate services:

1. Identify the client's specific problem. It is advantageous for the social worker to see the problem from the client's perspective. A clear understanding of the client's concern is vital for making an effective linkage.

2. When referring a client to an agency, be sure to give the name of a contact person. Just knowing that an agency exists is often not enough. Having someone on the agency staff act as a contact person can give the client a greater sense of control.

3. Be able to list and describe the services offered by the agency.

4. Know the eligibility requirements to receive service from the agency.

5. Be prepared to assist the client in the application process for services.

6. Know what type of payment is accepted by the agency. Does it accept Medicaid/Medicare? What about insurance?

7. Know whether the agency provides transportation (ie. van service) to and from the facility.

8. Be able to inform your client of the most convenient parking area and the cost involved to park there (if any).

9. Provide a map or clear directions to the agency.

10. Know whether the agency has bilingual employees available to act as translators.

Hints for making referrals:

1. Be clear about the reason that referral is under consideration.

2. Referral is appropriate when the worker and his or her agency cannot provide the service or type of assistance needed.

3. Referral is appropriate when the worker has reason to believe his or her own values, attitudes, or religious beliefs will be a barrier to developing an effective helping relationship.

4. "Passing the buck" or "dumping" a difficult client onto another agency is both unprofessional and unethical.

5. Be realistic about what other agencies and professionals have to offer your client.

6. Make sure you know of all agencies already involved with a client before considering a referral.

7. Be sure to obtain releases of information signed by the client prior to engaging in the referral process.

8. Consider the client's friends, relatives, neighbors, natural helpers, and other informal resources as a possible source of assistance.

9. Whenever possible and appropriate, the client's family and other significant individuals should be involved in the decision making related to a referral.

10. If a referral is made, it is important to evaluate your referral work. Do a follow-up evaluation to assess whether the client actually received what he or she needed to make progress in resolving the presenting problem.

TEXAS DEPARTMENT OF HUMAN SERVICES

COMMUNITY CARE FOR AGED AND DISABLED

Services:

1. **Family Care** - Services are provided by contract agencies to individuals in their own homes and include: personal care, household tasks, supervision, meal preparation and escort shopping.

2. **Primary Home Care** - An in-home, non-technical medical service for person whose health problems cause them to be functionally limited in activities of daily living. Essential housekeeping and personal care are provided by contract agencies in the clients home. A physicians orders and supervision by a registered nurse is required. **Eligible clients are those receiving SSI or Waiver V.**

3. **Day Activities and Health Services** - Nursing and personal care services, physical rehabilitative services, nutrition services transportation services and other supportive services delivered outside of the client's home at a facility licensed by the Texas Department of Health and certified at least 10 hours a day, Monday through Friday.

4. **Supervised Living Services** - Provider agencies serve eligible clients who require access to services on a 24-hour basis, but not daily nursing intervention. Facilities for supervised living may be nursing home wings, apartments, etc. Services may include room, room and board, protective supervision, personal care, social and recreational services, housekeeping and laundry, and transportation services. It is generally for continent, non-wandering patients. This service involves a co-payment system. If able, clients must contribute to the cost of care.

5. **Adult Foster Care** - This living arrangement may include such services as protective supervision, help with daily activities, and other support services. The services are furnished in the home of a provider both which are certified by TDHS.

6. **Special Services to the Handicapped** - Provider agencies assist handicapped individuals to achieve habilitative or rehabilitative goals. Services include counseling, persona care, and assistance with the development of skills needed for independent living in the community. Support services may include transportation and information and referral.

7. **Emergency Response System** - An electronic monitoring system for functionally impaired person living alone.

8. **Home Delivered Meals** - Provider agencies are contracted to deliver meals to the client's home.

9. **Emergency Care Services** - Care for eligible clients in an emergency situation while a permanent care arrangement is being arranged.

10. **Case Management** - TDHS provide eligibility determinations, assessments of clients needs, service plan development, information and referral, and monitoring of clients and services delivery.

TOLL-FREE NUMBERS IN TEXAS

AARP: General Information	1-800-424-2277
Aging, National Council on the Aging, Inc.	1-800-424-9046
Alcoholism & Drug Dependence (Nat'l Council)	1-800-622-2255
Alzheimer's Disease & Related Disorders	1-800-272-3900
American Society on Aging	1-800-537-9728
Arthritis Foundation - Information	1-800-442-6653
Cancer Society, American	1-800-227-2345
Cancer Information Service of Texas	1-800-422-6237
Dental Association, Texas (Senior Dent Program)	1-800-460-8700
Diabetes Association, American	1-800-232-3472
Drug & Alcohol Abuse, Nat'l Clearinghouse	1-800-729-6686
Eyecare Helpline	1-800-222-3937
Health, Department of (Info on services)	1-800-458-7111
Health Information Clearinghouse, National	1-800-336-4797
Hearing Helpline - Better Hearing Institute	1-800-327-9355
Hearing Test	1-800-222-3277
Lifeline (Emergency Response System, National)	1-800-451-0525
Lung Association of Texas, American	1-800-252-5864
Mental Health & Mental Retardation, Texas Department of (client services)	1-800-252-8154
National Council on the Aging	1-800-424-9046
Suicide and Crisis Center - "The Listeners"	1-800-692-4039
Texas Department on Aging	1-800-252-9240

Adapted from Elder Care: Family Training and Support by Amanda Smith Barusch, 1991. ISBN 0-8039-4227-3 cloth, ISBN 0-8039-4185-4 paper.

SOURCES OF INFORMAL SERVICES

Spouse: They usually serve as the first caregiver; this is particularly true for men. Older men are twice as likely to be married as older women. In 1989, there were five times as many widows(8.3 million) as widowers (1.7 million) (AARP, 1990). Most men have access to a spouse for assistance.

Adult Children: A 1986 study found that 4 of every 5 older persons have living children. Two-thirds of these live within 30 minutes of a child (AARP, 1990). Only 18% of those 65 years old live in the same house with one of their children (Shanas, 1980). The relationship between older parent and adult children generally involves active exchanges of visits and assistance. Six out of ten have at least weekly visits with their children. Older adults may help with babysitting or making gifts for grandchildren, and receive help with home repairs and housework.

Grandchildren: The vast majority (94%) of elderly who have children have grandchildren (Shanas, 1980). Grandchildren are often willing to help in caregiving. However, their level of involvement depends largely on the attitudes of the older family members, both parents and grandparents. Grandchildren are a valuable, but unrecognized, source of assistance.

Siblings and Distant Relatives: They can be an important resource for those elders who have no closer kin. Approximately 13% of people over 65 have neither spouse nor children on whom to rely (Barusch, 1987). These people turn to sibling and distant relations for assistance. For those who never married or are widowed without children, nieces and nephews are a vital part of their support system. Often, the degree of involvement depends on the strength of the bond between the siblings in the older generation.

Friends and Neighbors: Friends are most often age peers, so they may have more in common with the caregiver or care receivers. They may be better able to understand and empathize, thus providing a valuable source of emotional support. Typically, friends and neighbors do not provide long-term, intense care. Instead, they are there to provide help with emergencies and minor tasks.

Churches: The church provides a very important role of the support system for many elderly, especially for minority populations. Minorities generally are more skeptical of physicians, social workers, and government officials. They are apt to be unaware of existing services. The church is a culturally bond organization sensitive to the unique culture of the group. It does not only provide spiritual support but social and emotional support as well.

FINANCIAL ISSUES

Major Programs that Fund Long-Term Care Services
-- U.S. Congress, Office of Technology Assessment

Major Federal Programs Funding Community Services for the Elderly

Medicare and Medicaid Explained -- Living Centers of America

Table 1-Major Programs That Fund Long-Term Care Services

Medicare/Title XVIII of the Social Security Act

Medicare is the Federal insurance program intended to provide medical care for elderly people. Generally those who are 65 or older are eligible, and about 95 percent of these Americans are enrolled in Medicare. People under 65 who have been receiving social security disability payments for at least 2 years are also eligible. Medicare provides reimbursement for hospital and physician services and limited benefits for skilled nursing home care, home health care, and hospice. By law, Medicare does not cover custodial care.

Medicaid/Title XIX of the Social Security Act

Medicaid is the joint Federal/State program intended to provide medical and health-related services for low-income individuals. Medicaid regulations are established by each State within Federal guidelines; eligibility requirements and the long-term care services that are covered vary significantly among the States. In general, however, Medicaid pays for nursing home and home health care for individuals who meet financial and medical eligibility requirements. In some States Medicaid also covers adult day care and in-home services such as personal care and homemaker services.

Social Services Block Grant/Title XX of the Social Security Act

The Social Services Block Grant provides Federal funding to States for social services for elderly and disabled people, among others. There are no Federal requirements for specific services that must be provided, but many States use a portion of their Social Services Block Grant funds for board and care, adult day care, home health aide, homemaker, and chore services. States determine the eligibility requirements for these services and may require means tests.

Title III of the Older Americans Act

Title III of the Older Americans Act provides Federal funding to States for social services for people over 60. The specific services that are provided are determined by each State and local Area Agencies on Aging, but Title III funds are often used for home health aide, homemaker, and chore services; telephone reassurance; adult day care; respite care; case management; and congregate and home-delivered meals. Means tests are not used to determine eligibility, but Title III services are supposed to be targeted to elderly people with social or economic need.

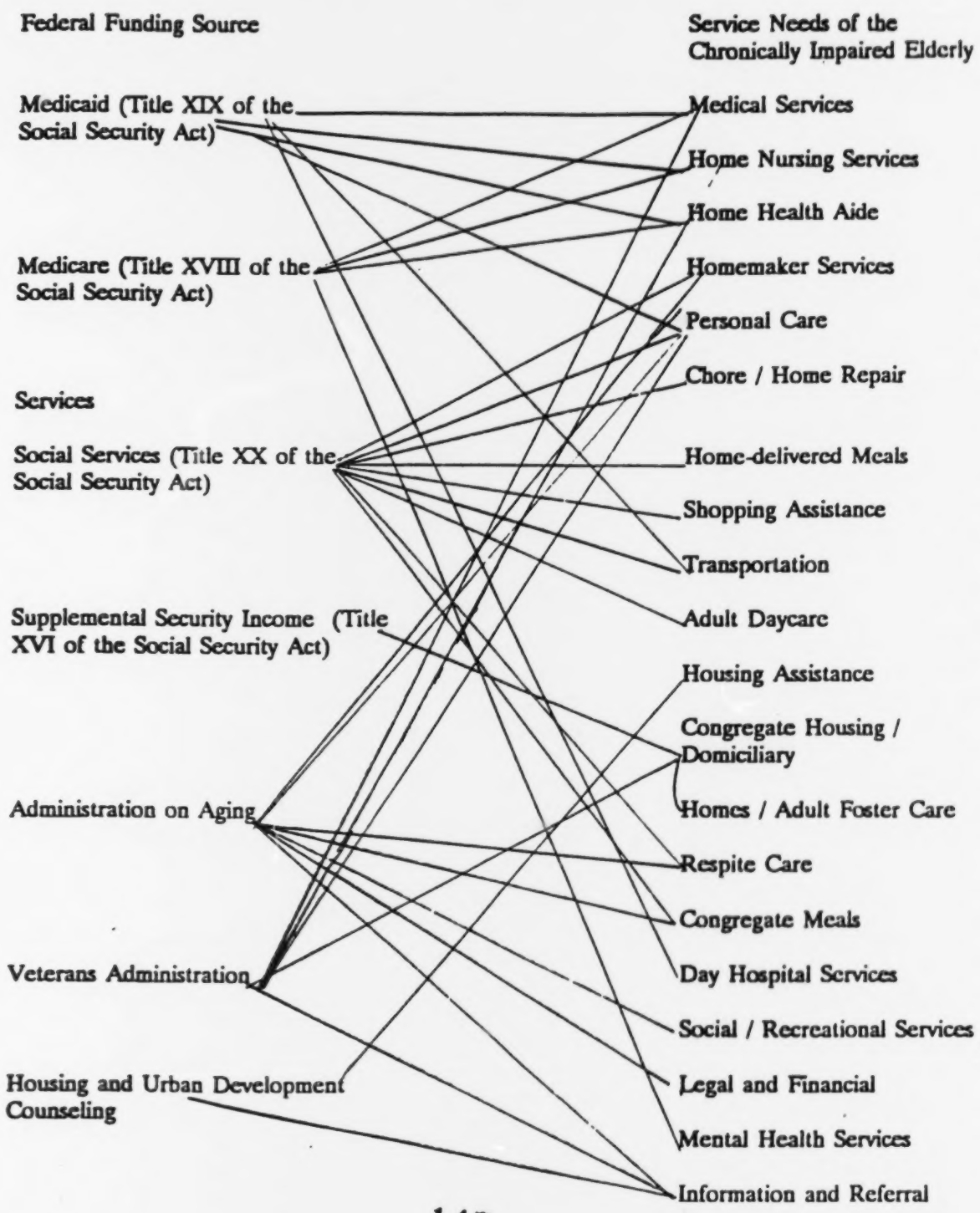
Supplemental Security Income (SSI)

SSI is the Federal income support program that provides monthly payments to aged, disabled, and blind people with incomes below a minimum standard ($336 for individuals and $504 for couples in 1986) and assets below $1,700 for individuals and $2,550 for couples. States may supplement the Federal benefit for all SSI recipients in the State or for specified groups, such as those living in board and care facilities. Some States also provide SSI supplements for home health care and homemaker services.

BEST COPY AVAILABLE

Source: U.S. Congress, Office of Technology Assessment, Technology and Aging in America- 1985.

MAJOR FEDERAL PROGRAMS FUNDING
COMMUNITY SERVICES FOR THE ELDERLY



MEDICARE AND MEDICAID

Information on the following pages was obtained from two brochures produced annually by Living Centers of America. Copies of the brochure are available from 1-800-272-CARE.

Further information is available from the following sources: **Medicare**, contact the Social Security Administration Office at 1-800-772-1213 to request a Medicare Handbook and for **Medicaid**, contact the Texas Department of Health at 1-800-252-9263 for a Medicaid User's Guide.

MEDICARE

Medicare is a comprehensive health insurance program for persons age 65 or older, persons permanently disabled for at least 24 months, or persons with end stage renal disease. Medicare covers acute care in a hospital, Medicare-certified skilled care in a nursing facility, and home health services. Most nursing facilities provide more than one level of care. An assessment of each patient's medical condition and care needs is used to determine the level of care provided to that patient.

Benefit Period:

Medicare coverage for inpatient hospital benefits and for long-term benefits in a Medicare-certified skilled care unit are based on a concept known as a benefit period. During a benefit period, Medicare will cover a specified number of days of acute care in a hospital and of long-term care in a skilled nursing facility for a particular spell of illness. The benefit period usually begins when the patient is admitted as an inpatient to a hospital. If the patient is discharged from the hospital and subsequently admitted to a nursing facility's Medicare-certified skilled care unit within a specified time period, the benefit period continues. The benefit period ends when the patient is no longer under the spell of illness that caused the start of the benefit period. Usually this happens (and a new benefit period can begin) when a patient has been at a lesser level of care, not requiring daily skilled services for 60 consecutive days.

Generally, to be eligible for Medicare coverage, the patient must have been hospitalized for a minimum of three days and be admitted to the Medicare-certified skilled care unit within 30 days after the hospital discharge.

Medicare Coverage:

There are two parts to Medicare coverage: Part A and Part B.

Part A Covered Services. Part A helps pay for medically necessary inpatient care in a hospital and in a nursing facility's Medicare-certified skilled care unit. It also pays for care at home under the supervision of a home health agency. For care in a hospital, the patient pays a $676 deductible per benefit period and Medicare will pay the remainder for the first 60 days of care. During the 61st-90th days, the patient must pay a coinsurance of $169 per day.

In a nursing facility's Medicare-certified skilled care unit, Part A covered services include a semi-private room, meals, nursing services, rehabilitation services, drugs, medical and nursing supplies, and needed medical equipment. Medicare will pay 100 percent of the cost for the first 20 days of nursing care in a nursing facility's Medicare-certified skilled care unit. For the 21st - 100th days, the patient must pay $84.50 per day coinsurance.

Part B Optional Services: Medicare charges a monthly premium of $36.60 for this optional coverage. Part B covers additional services. For patients in a nursing facility who are not covered by Part A, Part B will cover such services as physical occupational, and speech therapies, certain medical supplies, and portable x-ray services. Other types of services covered by Part B include physician fees, prescription drugs that cannot be self-administered, and outpatient hospital services. After the patient pays the annual $100 deductible, Medicare pays 80 percent of "customary charges." The patient must pay the remainder 20 percent. There are not time limits on Part B coverage as there are on Part A.

MEDICAID

Medicaid is a medical assistance program that helps states provide health care services for needy and low-income individuals. Most states provide Medicaid services to "categorically needy" individuals--people who receive benefits from federal assistance programs. Those entitled to receive benefits include:

- The aged, blind and disabled receiving cash assistance from the federal Supplemental Security Income (SSI) program.
- Recipients of Aid to Families With Dependent Children (AFDC).
- Pregnant women and children under age 6 whose family income does not exceed 133 percent of the federal poverty line (see page XX).

Many states also choose to provide Medicaid services to "medically needy" individuals:

- Other low-income individuals who may not quality for federally-funded assistance programs, but whose income after medical expenses is below a certain level set by their state.

The federal government shares the cost of Medicaid services with the state. Federal funds contribute 50 percent to 78 percent of the health care costs for eligible needy and low-income individuals. Individual states pay the remaining costs for Medicaid programs with help from local governments.

What services are covered?: Each state designs and runs its own Medicaid program. For this reason, covered services and eligibility requirements vary from state to state. Basic Medicaid health services that all states cover (at least partially) include:

- Inpatient hospital care
- Outpatient hospital services
- Laboratory and x-ray services
- Nursing facility services at a Medicaid-certified facility for individuals 21 and older
- Home health services for individuals 21 and older
- Physician services
- Screening, diagnosis and treatment of individuals under 21
- Family planning services
- Nurse-Midwife services
- Rural health clinic services
- Nurse Practitioners' services
- Transportation service

Optional services: Medicaid may help to pay for additional services. Some of the most frequently covered optional services include clinic services, intermediate care facility services for individuals with mental retardation, optometrist services and eyeglasses, prescribed drugs, case management services, prosthetic devices and dental services.

Medicaid eligibility: Each state sets its own eligibility requirements. If an individual does not receive aid from a federal assistance program, Medicaid determines eligibility based on available income and resources. The financial eligibility standards that govern Medicaid eligibility allow an individual, a couple or a family to keep a small amount of income plus certain resources.

To establish income levels for Medicaid eligibility, the state sets an amount that it considers to be the minimum cost of the basic necessities of living (adjusted for family size). If available family income is beneath Medicaid standards, members of the family may be eligible for Medicaid benefits. Resources such as a house, a car and limited amounts of other property are not usually counted in determining income or resource levels.

To receive Medicaid coverage for hospital or nursing home services, states require that the applicant meet basic medical criteria. Staff at the hospital or nursing home can assist with completing necessary forms and providing proof of medical need.

For spouses of nursing home residents: When a married person lives in a nursing home, the law protects his or her spouse from being reduced to poverty to qualify the infirm spouse for Medicaid. The couple is permitted to keep a higher level of assets than unmarried Medicaid applicants while still qualifying for Medicaid. In addition, higher levels of the couple's income are protected from liability for the costs of nursing home care.

The spouse living at home can keep enough of the couple's income to stay above 150 percent of the federal poverty line for a family of two. Certain income of the at-home spouse and the couple's home, car, household furnishings and certain other specified items continue to be exempt when determining whether the applicant's income and resources meet Medicaid's eligibility rules.

Medicaid qualifying trusts: An individual may prevent resources from being counted in determining Medicaid eligibility or from being paid to a nursing facility by placing them in a Medicaid-qualifying trust. This type of trust is established (other than by will) by an individual or the individual's spouse and allows the individual to be the beneficiary of all or part of the payments from the trust. Except in cases of undue hardship, as determined by the state, all funds that can be paid to the individual under the terms of the trust are deemed available to pay for medical or nursing facility care even if the individual does not receive those funds. Any individual who forms such a trust should consider whether the trust violates the Medicaid transfer-of-resources rule and should be aware that the funds in the trust may be subject to recovery by the state upon the individual's death. Individuals considering such a trust should consult an attorney.

Medicare premiums: Medicaid pays the Medicare premiums, deductibles and coinsurance for certain low-income elderly and disabled people in the Medicare Part A Hospital Insurance program and the Medicare Part B Medical Insurance program. This provision applies to individuals with income under 100 percent of the federal poverty line.

Medicaid also pays premiums for Medicare Part A coverage for certain working disabled people. These are people who have incomes below 200 percent of the federal poverty line and limited resources, but whose income and resources render them ineligible for Medicaid.

AIDS: Medicaid is the largest single source of payment for health care services for individuals with AIDS. Medicaid now pays for the health care costs of 40 percent of all AIDS patients and 90 percent of the children and infants with AIDS.

Coordinated care: States have the option to provide Medicaid services through coordinated care plans such as those provided by health maintenance organizations (HMOs). These organizations assure access to physicians who provide primary care and who refer patients to specialists and for hospital care.

Paying for services: States pay providers directly for Medicaid health care services. States may require individuals to apply any monthly income they receive to the cost of services, except a specified amount for personal needs. Otherwise, providers such as hospitals, nursing homes and physicians must accept the Medicaid rate as payment in full. States have the option to impose nominal coinsurance or deductibles for certain services.

Applying for Medicaid: Anyone can apply for Medicaid. Applicants must fill out an application provided by the state (information is confidential). Individuals who especially should apply:

- Have dependent children and a low income.
- Have high medical costs in relation to income.
- Are aged, blind or disabled with little or no income.

Medicaid applications may be made at local state welfare, public health or social service agencies. Call the local welfare or Social Security office for an appointment and for more details on the Medicaid application process. A representative will help complete the application and tell you of any additional documents that are needed.

Items generally needed when applying for Medicaid are:

- **Proof of income** (proof of wages or earnings, Social Security or veterans benefits, private pension benefits, royalty or rental payments, railroad retirement benefits, civil service annuities, state or local retirement benefits, gifts or contributions, wages or earnings of relatives living in the same household, etc.).

- **Proof of resources** (proof of bank accounts and certificates of deposit, real property, life insurance policies, burial plots and funds, stocks and bonds, oil/gas/mineral rights, jewelry and antiques, cars/vehicles.
- **Proof of U.S. citizenship or alien with approved status** (birth certificate, voter's registration card, Social Security card, passport or legalized or permanent resident alien).
- **Proof of disability, if any** (bring medical records). The state must make a decision about eligibility within 45 days (90 days for disabled individuals; there is no time limit if applying through the Supplemental Security Income Program). Applicants have the right to appeal the state's decision. Any resident of a state may qualify for Medicaid. It is not necessary to live in the state for set period of time, but the individual must intend to remain in the state.

Fraud and ineligibility: Intentionally providing false information or withholding information, may subject the individual to prosecution for fraud under the laws of the state. Giving away or selling assets or resources for less than market value in an attempt to meet eligibility requirements may cause an individual to be found ineligible for medical assistance. The state may consider this action as giving away a resource that could be used for support. Laws under the Medicaid Coverage Act set strict guidelines for disposing of or transferring assets up to 30 months before applying for Medicaid.

THE TEXAS MEDICAID PROGRAM

Covered services: Medicaid services in Texas are provided to the "categorically needy"--individuals who receive assistance from federally-funded programs such as Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). Medicaid services are also available to medically needy individuals--other low-income individuals who may not qualify for federally-funded assistance programs, but whose income after medical expenses is below a certain level set by the state.

In addition to the services that all states cover under Medicaid (listed earlier), the Texas Medicaid program also will cover (at least partially) the following optional services:

- Podiatrist services
- Optometrist services
- Chiropractor services
- Other practitioner services
- Clinic services
- Physical therapy
- Prescribed drugs
- Prosthetic devices
- Eyeglasses
- Diagnostic services
- Rehabilitative services
- Intermediate care facility services for individuals with mental retardation
- Nursing facility services for individuals under age 21
- Emergency hospital services
- personal care services
- Transportation services
- Case management services
- Hospice care services
- Respiratory care services

Again, the above services are covered (at least partially) through Medicaid to categorically needy individuals and certain medically needy individuals.

Eligibility criteria for long-term care: The responsible party of the individual who will receive Medicaid services is responsible for applying for Medicaid with the Texas Department of Human Services. To be eligible for Medicaid services, an individual must qualify both medically and financially. You cannot qualify if you are only financially eligible or only medically eligible.

Medical eligibility: State form #3652, "Level of Care Assessment," must be completed before an individual can be admitted under Medicaid to a long-term care facility. The nursing facility administrator or director of nurses will be glad to assist in the processing of this form. If the individual is in the hospital, the discharge planner can help to obtain a medical level of care assessment before the individual is admitted to a long-term care facility.

Financial eligibility: The following are some of the guidelines for financial eligibility under the Texas Medicaid program:

1. If you receive assistance from the federal Supplemental Security Income (SSI) program, you automatically meet financial eligibility for Medicaid. You are eligible for nursing home care, provided you also are given a medical level of care verifying your need for long-term care.

2. If you do not receive SSI, you must apply for Medicaid and meet the following financial guidelines: (As of 8/93)

    - Monthly income cannot exceed $1,302 for an individual; 2,604 for a couple.
    - Resources cannot exceed $2,000 for an individual; $3,000 for a couple.

What counts as income?:

- Social Security benefits
- Veterans benefits
- Private pension benefits
- Interest or dividends
- Earnings or wages
- Civil service annuities
- Railroad retirement benefits
- State/local retirement benefits
- Gifts or contributions
- Royalty and rental payments

What counts as resources?:

- Bank accounts and certificates of deposit
- Real property
- Life insurance
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles

What resources can be excluded?:

- Homestead where the individual intends to return or where a spouse lives.
- Life insurance if the face value is $1,500 or less.
- Burial funds of $1,500 (less any excluded life insurance).
- Care worth less than $4,500, or more if needed for medical transportation.
- Burial spaces for the individual, spouse, and close relatives.

What is the amount of protected resources for a spouse living in the community?: To calculate the amount of protected resources, Medicaid will determine the couple's countable resources at the time infirm spouse is admitted to the long-term care facility. The total amount of protected resources is the greater of two-numbers-- either $14,148 or one-half of the amount of countable resources. The maximum amount of protected resources is $70,740.

For example, let's say a couple's total mount of countable resources at the time the inform spouse is admitted to the long-term care facility is $20,000. One-half of this amount is $10,000. Since $14,148 is greater than $10,000, then the amount of protected resources in this case would be $14,148.

Now let's say a couple's total amount of countable resources at the time the infirm spouse is admitted to the long-term care facility is $40,000. One-half of this amount is $20,000. Since $20,000 is greater than $14,148, then the amount of protected resources in this case would be $20,000.

Again, the maximum amount of protected resources is $70,740.

What is meant by "spending down" resources?: Couples must "spend down" their unprotected resources. Once the couple spends down their total resources to the protected resources amount, plus $2,000 (the exempt resources amount allowed for the nursing home spouse), the spouse in the nursing home meets the resource test to be eligible for Medicaid.

Other eligibility criteria:

- *Residency* - must be a resident of Texas and a U.S. citizen or an alien with approved status (i.e., legalized or permanent resident alien).
- *Living arrangement* - must be a patient in a Medicaid-certified long-term care facility for 30 consecutive days.

Income applied to cost services:

- *Individual*: The total monthly gross income of the individual admitted to the nursing facility - less $30 for personal needs - is applied to the cost of Medicaid services. For example, individuals receiving monthly social security checks would keep $30 of the check and pay the remaining amount to the nursing facility for the cost of Medicaid services.
- *Individual with a spouse in the community*: The total monthly gross income of the individual and spouse - less $30 for the individual's personal needs, a maximum of $1,769 for the spouse, and a certain amount for any dependents living with the spouse - is applied to the cost of Medicaid services.
- *Couple*: The total monthly gross income of the couple - less $60 for personal needs - is applied to the cost of Medicaid services.

Size of Family Unit	Poverty Guidelines
1	$ 6,970
2	9,430
3	11,890
4	14,350
5	16,810
6	19,270
7	21,730
8	24,190

*For family units with more than eight members, add $2,460 for each additional member.

LEGAL AND ETHICAL ISSUES

"Case Management: Ethical Pitfalls on the Road to High-Quality Managed Care" -- R. Kane

"New Laws on Patient Treatment Decisions" -- J. P. Hopkins

Texas Natural Death Act: Guidelines and Directives

Information Concerning the Durable Power of Attorney for Health Care

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Special Article

Case Management: Ethical Pitfalls on the Road to High-Quality Managed Care

Rosalie A. Kane, DSW

Case management in long term care (LTC) has proliferated without full agreement about its appropriate definition, purpose, auspices, or authority. Nevertheless, a consensus is emerging in favor of case management, not only in LTC for the elderly, but also in programs serving other populations (eg, the chronically mentally ill or the developmentally disabled) and in comprehensive programs that deliver both acute care and LTC to the elderly on a capitated basis.

The current enthusiasm for case management may be justified by outcomes for those served. Under the proper circumstances, case management can be a powerful tool to improve the quality of care and the fairness and appropriateness of its allocation. But safeguards and adequate forethought are necessary to ensure that managed care meets often subtle ethical challenges. This article suggests a framework for examining the ethical issues raised by case management.

In the vague language of the 1980 Budget Reconciliation Act (which permitted states to apply for Medicaid waivers to offer a broad array of community-based LTC services, with case management at the top of the list), case management is coordination of a specific group of services on behalf of a specific group of people. Case management can also be defined by listing its component processes. By widespread agreement, these processes include screening or case finding; comprehensive, multidimensional assessment; care planning; implementation of the plan; monitoring; and reassessment (at regular intervals to restart the process and as requested by both client and care providers). Case management often also includes authority to purchase services for the client, authorize third-party reimbursement, and/or establish eligibility for public entitlements based on the client's functional impairments.[1]

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Advocacy Versus Resource Control

Case management represents a convergence of two distinctive approaches to improving care. One approach stresses client advocacy; the other emphasizes resource allocation. The first position holds that users of health care—particularly the vulnerable elderly and disabled in the midst of a health crisis—need skilled and specialized help to find the resources that match their needs. Thus, a case manager does a detailed assessment of those needs, clarifies the range of options, explains the mysteries of fragmented public entitlements, helps the client and family make a decision, and acts as an advocate in helping the client find affordable services of adequate quality. The roots of these approaches are deep in the traditional perspectives of social work, public health nursing, and other helping professions—so much so that some skeptics claim that not much is new about case management. Arguably, case management has been and is performed by hospital social workers at discharge, by nurse coordinators of home health agencies, and by a host of others.

A second perspective on case management stems from a variety of efforts to allocate services appropriately in a community, use resources wisely for those most in need, document inadequacies of total resources for planning purposes, and introduce systemwide incentives to improve the quality of all care providers in the community. Case managers with this perspective generally are found in positions where they can exert real control over resources, for example, in community-based LTC programs funded by Medicaid waivers,[2] in capitated, prepaid health care systems such as health maintenance organizations with enriched LTC components, and in private LTC insurance.[4] Such case managers are sometimes considered "gatekeepers" to care programs.

At first blush, a gatekeeper is at variance with an advocate. A gatekeeper controls entry to programs and intensity of service within them, whereas an advocate strives to gain the most for each client. An extreme position in favor of the pure advocacy role conceives the case manager as a broker, whose ethical obligations are solely directed toward the functionally impaired client. Indeed, a brisk cottage industry of private, fee-for-service case management has sprung up, particularly in retirement areas, to provide just this type of attention and advocacy to those who can afford it.

The first ethically tinged question to be resolved, then, is whether it is possible for a case manager to simultaneously serve as an advocate for a client or patient and as an agent of "the system." If one takes the position that this dual stance is impossible, one either develops procedures to ensure that each client has an independent case manager as adviser, or one abandons, as a fiction, the idea that case managers with control over resources can truly be client advocates.

Fortunately, the role of advocate and the role of gatekeeper can be reconciled

"In LTC, there is an ever-present danger that patients are discounted as competent decision makers merely because they judge the situation differently from the professionals."

ethically as long as the case management program is designed to serve an entire population at risk with a finite set of resources. In that case, the community of actual and potential LTC users in a geographic area or a defined population group is the clientele. The case manager becomes an advocate for identifying and meeting the needs of the entire group fairly and well, as well as for meeting the needs of any given individual. Moreover, even case managers with no gatekeeping authority face the problem of mixed loyalties whenever their advocacy extends to the well-being of the client's family. (Conflict of interest most likely occurs in situations where a fee-for-service case manager is hired and paid by a family member to manage the case of an elderly relative.[6])

The difficulties of balancing advocacy and gatekeeping challenge the case manager, often contributing to stress and uncertainty in the job. Arguably, however, no irreconcilable ethical problem prevents this model of service. Moreover, as will become apparent from the remainder of this article, severe conflicts of interest can emerge when case managers are also service providers rather than relatively disinterested allocators of service.

Autonomy Versus Beneficence

Biomedical ethics, particularly in the United States, has been preoccupied with reconciling the principle of autonomy—that is, the right of persons to be protected from unwanted force or interference—and the principles of beneficence or nonmaleficence—that is, the moral obligation to do good and not do harm.[7-9] The principle of autonomy obliges case managers to refrain from interfering with decisions that competent persons make about their own lives unless those decisions harm others. The principles of beneficence and nonmaleficence oblige case managers to act in the best interest of the clients.

Regardless of whether the case manager has a mixed gatekeeping/advocacy role or a pure advocacy role, the reconciliation of autonomy and beneficence creates ethical dilemmas. These are similar in kind to those faced in clinical care by physicians, nurses, social workers, and others who struggle to balance their professional judgment about what is good for the patient with respect for the patient's autonomy. The case management function introduces some new and subtle elements to this familiar problem.

Autonomy. Case management is fraught with dangers to the client's autonomy, some inherently perplexing and others resolvable by conscious informed-consent procedures and other autonomy-enhancing processes.

Many autonomy issues arising in case management are not limited to that function but occur in all work with the elderly in LTC. Among the intractable but rather generic problems is the issue of deciding when a person is competent to make various types of decisions. Most LTC users who are said to be impaired in decision making have not undergone a judicial process to establish legal competence. Indeed, such a process may not even serve the best interests of the functionally impaired person; legal competence is an either-or attribute, whereas decisional capacity is relative to the type of decision that needs to be made and the fluctuating abilities of the patient.[10] In LTC, there is an ever-present danger that patients are discounted as competent decision makers merely because they judge the situation differently from the professionals. A case manager may view a patient's risk taking or refusal of professional advice as evidence of incompetence, whereas to the patient, it represents a conscious, rational choice.

Another difficult issue is balancing the autonomy of family members who care for the frail elderly with the autonomy of the functionally impaired persons themselves. A client may adamantly prefer living in the community, but exercise of this autonomous choice may impose heavy constraints on a spouse or adult offspring. Case managers with control over resources typically cannot authorize expenditures in the community that are higher than the cost of nursing home care for the same person. The more impaired the client's functioning, the more likely that a plan of community care will

depend on the unpaid labor of family.

Leaving aside the question of decision-making competence and the possibly competing interests of family members, the case management situation affords many opportunities for paternalism on the part of case managers. (Paternalism refers to overruling a person's autonomy *for that person's own good.*)

Case managers, by definition, are experts with expert opinions and specialized knowledge. They may tend to discount the client's view about the kinds of services needed in the home—even though the nature of those services can determine intimate details of the client's daily life. For example, the care package embodies decisions about the timing of intimate care, such as bathing and toileting, and about who provides that care (eg, a male or a female attendant, if the service is included in the care package or, by default, a member of the client's family). Case managers may find themselves arguing for more or less care or different service packages than the client prefers; for example, they may limit the plan to services in the home when the client wishes help in going for walks and shopping, or the client and case manager may disagree on the use of home-delivered meals or day care.

Case managers may overlook the client's preferences on small details (such as arrangements for times of visits) or larger matters (such as honoring requests not to contact a relative). The case manager may believe that the client needs a "period of adjustment" to accept a particular service—for example, day care—and override the client's objections to trying it. Case managers may even collude with families on such plans. Or a case manager may believe that a technique bordering on coercion will enhance the client's independence in the long run. For example, the case manager may believe that unless a client accepts a brief admission to a nursing home to give a few weeks of respite care to a family caregiver, the relative will arrange a long-term placement.

In all these examples, the definition of coercion is imprecise. A case manager can appropriately advise and persuade a client. Advice, persuasion, and marshalling information is hardly coercion; rather, it is application of expertise. But autonomy is violated if clients are manipulated into accepting plans on the false belief that no other plan is possible or from fear that services will be withdrawn if they resist. The line between persuasion and manipulation is particularly thin for vulnerable, physically dependent clients.

Autonomy demands that nobody's "case" be managed without consent. Further, clients must understand clearly what case management means before they can give informed consent. Health care providers are conscious of their duty to seek informed consent for medical procedures, and much has been written about the niceties of what constitutes a genuinely informed consent. In contrast, perhaps because case management seems benign compared to more invasive medical procedures, little attention has been given to consent for case management. The following issues need exploration:

- How should case management be described to the client?
- What are the benefits and risks of case management, and how should these be presented to the client?
- What rights need to be outlined to the client in advance? For example, must the client be informed if the case manager tries to obtain maximum help from relatives before offering any services? Do clients have the right to refuse involvement of their family members, or can the program require this as a condition of service?
- What confidentiality can the client expect of the information gathered in the client assessment? With whom will the information be shared?
- In many publicly subsidized programs, the case manager advises the client to choose the most parsimonious service plan possible and gives preference to services with no public costs. If these are the premises of the program, must those program characteristics be disclosed to the client in advance?
- If the client is incapable of giving initial or continuing consent, from whom is consent requested? Is a formal, legal adjudication of incompetence necessary so that consent can be requested of a legal guardian? What formal steps are needed in adjudication of incompetence to protect the client adequately? Who should be approached—the next of kin in some order of consanguinity, the most conveniently located next of kin, or the person whom the case manager thinks is most likely to be benevolent?

Care planning is an especially sensitive area. Although many case management programs are designed with the expectation that the case manager will involve the clients, determine client preferences, and sometimes even secure a signed agreement for a particular plan, the array of options presented is usually left to the discretion of the case manager. In one program where case managers had broad discretion to purchase almost anything (including equipment, home renovation, and even entertainment for client or family), the evaluation showed that the case managers recommended familiar services, such as home nursing, housekeeping, and social work counseling. Similarly, a problem with vermin in a client's apartment led to a purchase order for help in client relocation rather than to a logical but atypical order for an exterminator's services.

Furthermore, even though the signatures of both client and family caregivers were on file on the care plan, the evaluators found that clients seldom knew what menu of potential services they were choosing from and how they might have mixed and matched services to achieve a different plan for the same total costs.[11] The case manager's visits and various counseling services added costs that clients, if fully informed, might have traded for, say, small renovations in the kitchen.

In general, case managers should inform clients and their families of the basis for their recommendations, but the more controversial question is whether the case manager should provide in advance a menu of all possible services that might be included in the care plan, along with their unit prices. This "cafeteria approach," combined with a running total of costs accrued during the month or the year, would

engage clients in expressing preferences and making their own trade-offs. Arguably, however, the policy could also increase costs by promoting a belief that each client *should* use the maximum allowable dollars in a given time period.

Beneficence. Deciding when and to what extent a case manager should set aside the principle of autonomy is difficult. Once a principle of beneficence is acknowledged, even greater difficulties arise. If case managers are to do good, they must be able to choose the good course of action accurately. But what is good for a functionally impaired person? Is it even possible to reach a hierarchy of "the good" that ranks, say, physical well-being and safety? Is it better to seek present benefits of increased freedom of movement and independence at the risk of increased future disability and dependence—for example, as the result of a fall? Can a ranking of the good be developed to apply to all clients of a program, or must the preferences of each individual client be consulted? The LTC field is replete with unresolved dilemmas because little public dialogue has taken place regarding how outcomes should be valued.[12]

Then, too, the beneficent case manager would need to develop a hierarchy of good that ranks the well-being of the client (whatever priorities are given to the facets of well-being) with the well-being of spouses, adult children, and other relatives. What if the values traded off are the contentment of the client versus the economic interests of the family member? The beneficent case manager might also wish to consider the taxpayer's interests. Perhaps the case manager would act differently on behalf of a well-to-do client compared to one whose care plan is implemented at public expense.

Justice and Case Management

Thus far, the discussion has largely revolved around the ethical principles of autonomy and beneficence. A third important principle concerns justice. For case management, this includes fair decisions about who needs care, fair allocation of benefits and services (including the use of the case manager's time), and equitable ways to resolve disputes.

Just use of resources. In large-scale case management programs, resources are typically limited. The case manager is expected to contain program costs by controlling clients' access to services, particularly high-cost services. If decision rules are routinely applied to the client assessment data to determine the care plans, then the decisions will be fair in the sense that an exact translation is made from disability to service. But care planning by rote is likely to drive up costs while driving out flexible, innovative, client-centered plans. When left to their own imagination, clients will find ways to involve neighbors or nearby restaurants in providing care, sustenance, or transportation. Similarly, clients may find a "live-in" arrangement that (because of room and board considerations) would cost no more than a much less intensive service purchased from an agency.

In the interest of fairness, case managers puzzle over whether it is appropriate to acquiesce to clients' wishes for a particular form of care not only if the net result is greater costs but also if the likelihood of quality control is less. They also worry that the more demanding clients receive a disproportionate amount of service.

Some case managers have been accustomed to calculating costs carefully and interpreting cost constraints directly to clients. Some case management programs generate profiles of patient costs so that case managers can compare typical resource consumption among persons with comparable disability levels. In the view of one program administrator, such profiles prevent "a particularly demanding or a particularly likeable client from acquiring excessive services to the detriment of the program as a whole."[13] Along those lines, one might even argue that effective and fair advocacy as well as gatekeeping requires use of modern information technology to determine who is getting what from the common pot.

Once high-cost clients are identified, case managers find themselves on ethical thin ice. Typically, the case manager may discuss these costs with the client. The client may be told that although costs can temporarily rise above the norms, the situation cannot continue indefinitely. If the costs at home exceed the costs of a nursing home, the client may be urged to consider relocating. The major difficulty occurs when the client refuses the nursing home. At this juncture, some case managers would withdraw home-based services entirely because of an unwillingness to be responsible for a service plan that is less intense than they consider necessary. Other case managers would leave to the client the decision about whether to persist at home with less than optimal service and whether to take the associated risks. (Arguably, after all, a move to a nursing home is not risk free to the client, even though the case manager is less likely to consider those risks in advance or learn about the outcome afterward.)

Clearly, case managers should not impose their own views of acceptable risk on clients and families. But what are a case manager's rights when he or she cannot in good conscience accede to the plan the client prefers? Does the case manager have a duty to refer the case to another case manager? If several case managers and their supervisors agree that the client's choices are dangerous to self or society, is this a test of truth?

Case finding versus serving current caseload. Case finding—that is, identifying from a larger population those who need services—is one of the functions of case management. A question arises about how to distribute resources between promoting the program and screening potential clients in contrast to arranging services. Money

spent in case finding can be well spent if it permits preventive actions that minimize later problems. Case finding also is consistent with an obligation to identify the extent of need. Arguably, even if all needs cannot be met, the information forms the basis for reallocation of resources at a higher administrative level.

The problem is determining how far a program should go in case finding. Is it ethical, for example, to stop accepting new clients for a period in order to catch up on monitoring and reassessment of current clients? When this was done in Vancouver, British Columbia, for a citywide LTC program, case managers identified substantial numbers of clients served at too high a level and, thus, theoretically freed resources to be used to serve new enrollees better.[1] Logical as it sounds, however, curtailing intake is a drastic step for a community program.

Potential conflicts of interest. Many agencies sense that case management is a growing market. Indeed, a diverse cast of organizations is doing case management. Agencies often argue against a "single-entry," case-managed system—that is, a system requiring that all those seeking subsidized community care apply to or be referred to a single agency, such as the local health department or the local area agency on aging, for assessment and ongoing case management. Often, community agencies prefer viewing case management as a reimbursable service that can be offered equally reasonably by a number of agencies and that can be purchased by public programs.

In a middle position, some argue for separating gatekeeping from the clinical functions (eg, assessment and care planning) and the advocacy functions. In such a scheme, there could still be a single point of accountability, but the case managers, acting as gatekeepers, would rely on data supplied by contracting agencies to determine initial eligibility and to approve changes in service plans. If multiple agencies perform case management in a given community, however, this ironically introduces duplication and fragmentation into a service that is expected to be a unifying and rationalizing force.

Public policy probably should not prevent any agency from offering a service it perceives as necessary and that it can finance from fees or charitable contributions. On the other hand, it may be irresponsible for those that finance programs to delegate the case management function and, with it, the allocation of services. Most important, a conflict of interest is possible when agencies that provide services also do the assessments of need for service and make care plans. This encourages case managers to identify a need for the services their own organization provides and to direct toward their agency the most desirable or profitable clients.

Competence and Case Management

Standards for case management. Ethical practice must, at the least, meet standards of competence. A case management program is unethical if it permits case managers to be derelict in their duties or to function without adequate training or skill. Here we encounter the difficulty that no particular standard has been established for case management. Anyone can set himself or herself up as a private case manager, and agencies have widely varying hiring practices and expectations for performance. Moreover, a credentialing approach to standard setting (eg, insistence that all case managers be qualified social workers or nurses) would hardly guarantee competence but would definitely raise costs.

Competence in case management is better defined by the ability to perform the tasks required and, eventually, by the outcomes achieved, rather than by arbitrary training requirements. For the sake of discussion, the following abilities and attitudes might be expected of case managers:

- Knowledge about services in the community, including both the range of available services and the quality of different providers.
- Technical skill in conducting a comprehensive assessment of a client's functioning and social well-being, including the ability to discern when more specialized assessments are needed (eg, from a geriatric physician, a psychiatrist, a lawyer, or a home inspector).
- Commitment to improving the inherent capabilities of clients when possible, which in turn means undertaking the more time-consuming and difficult task of trying to rehabilitate and improve functioning when possible rather than offering services to compensate for a remediable impairment.
- Ability to anticipate the likely costs of care and to keep an accurate, ongoing record of actual costs. Especially when a maximum amount may be expended annually, the case manager has a duty to the client not to squander resources; competence includes an ability for sound economic planning.
- Prompt attention to referrals, requests for information, monitoring, and reassessment. The program may have a computerized system to aid in tracking the caseload, but the individual case manager must be well-enough organized to use it.

This list represents a beginning only. Other capabilities could be proposed, and eventually all structural and process criteria retained should be associated with desirable outcomes for the clients. It will also be desirable over time to develop a standard range of case management responses to particular circumstances so that each case manager need not invent the response to common situations and so that the adequacy of the case manager can be audited. Schneider, in particular, has advocated such procedural guidelines to answer questions about the desirable case management response to circumstances such as a client on six or more medications who is not under regular medical care or a moderately confused client who lives alone.[7] Although one must guard against becoming rigid or rule bound, some guidelines to "good practice" would surely be helpful to case managers.

Monitoring the quality of care plans. Along with case finding, assessment, and care planning, monitoring care is one of the functions of case management. Although potentially an important force for improving the overall quality of care, monitoring is one of the least well-specified aspects of case

management. Even the frequency of desirable monitoring is unclear, let alone the type of verification the case managers should seek to assure themselves of the adequacy of service. At the minimum, the case manager should know that the services ordered are delivered reliably, but beyond that they surely have some obligation to monitor the quality of the services they plan. Case management programs vary in the degree to which the case manager attempts to maintain a personal relationship with the client. But one can also ask whether case managers can be effective in monitoring care unless they enjoy a relationship of trust with the client.

The agencies contracted by case managers usually bear the legal responsibility for things that go wrong. But what is the moral responsibility of the case manager? How seriously should the client's complaints be taken? What are reasonable precautions for the case managers to take? Should the case manager be expected to monitor with particular vigilance certain types of providers (eg, nonagency providers) or under certain circumstances (eg, when the client is in the hospital and thus likely to be subject to hastily formed plans by a new cast of discharge planners[16])?

A case management program can be a powerful force for improving care in the community, particularly if it enjoys considerable purchasing power and uses that power to gradually exact higher standards from vendors of care. One possibility, however, is that case managers will become so liability conscious that they shy away from flexible care arrangements and insist on purchasing care from agencies so that the liability can be diffused. Yet community care can often be arranged less expensively and more satisfactorily from the consumer's perspective by using other than the established agency vendors. Therefore, it is useful to ask whether the case manager's monitoring responsibility is discharged by contracts with bonded agencies hiring licensed personnel or whether the monitoring function requires direct surveillance of the care.

Concluding Note

This article has presented numerous issues and questions and few answers. The discussion has amply illustrated that many technical aspects relating to case managers and management agencies are unsettled. Some might argue that it is premature to focus on ethics in a field that is ill defined and ever changing. Far from being premature, however, early discussion of ethical issues may suggest an appropriate direction for public policies and may even help us determine which models of case management to endorse and which to avoid.

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New laws on patient treatment decisions

Earlier this year, Rudy Linares was told he would have to get a court order to have his comatose 15-month old son disconnected from the respirator that had kept him alive for 8 months in a Chicago hospital. Instead, Mr Linares entered the hospital with a gun and held the hospital staff at bay while he removed the respirator, cradling his son in his arms until he died. For many, this incident illustrated the inadequacy of current laws in this area. Treatment decisions should be made by the patient (or his legal representative) and physician, with court involvement in limited cases only.

In the closing days of the session, the 71st Texas Legislature passed two bills dealing with health care decision making, which have significant implications for physicians and other health care providers. Senate Bill 1785, sponsored by Sen Chet Brooks (D-Pasadena), amends the Texas Natural Death Act and addresses some of the problems physicians have encountered in implementing treatment decisions under the act (1). House Bill 2098, sponsored by Rep Nancy McDonald (D-El Paso) and Sen John Montford (D-Lubbock), provides a durable power of attorney for health care (2). HB 2098 allows a competent adult to designate an agent to make health care decisions in the event of incompetence. This article summarizes the major provisions of these two bills and their effects on health care decision making.

Natural Death Act amendments—Senate Bill 1785

The Natural Death Act enacted in 1977 allows competent adults to direct in writing or orally that life-sustaining procedures be withheld or withdrawn in the event of a terminal condition (3). Amendments to the act in 1985 recognize similar decision making authority on behalf of an incompetent adult by an individual designated by the adult, a legal guardian, or family members (4). The act also allows implementation of decisions to withhold or withdraw life-sustaining procedures on behalf of a terminally ill minor (5). Although the provisions in the act are not mandatory, when treatment decisions are made according to the act's procedures, physicians (and other health care providers acting at the physician's direction) who participate in the withholding or withdrawal of life-sustaining procedures are immune from civil liability unless negligent, as well as any criminal act or unprofessional conduct unless negligent (6).

SCOPE

The most significant change made by SB 1785 is an expansion of the type of patient to whom the act applies. Before SB 1785, the act addressed the withholding or withdrawal of life-sustaining procedures only when death was imminent *with or without* life-sustaining procedures (7). To use the act's procedures, death had to be imminent "*whether or not* such procedures are utilized" (8). In comments to the Uniform Rights of the Terminally Ill Act, the National Conference of Commissioners on Uniform State Laws considered this limitation problematic (9). "Strictly speaking, if death is 'imminent,' even with the full application of life-sustaining treatment, there is little point in having a statute permitting withdrawal of such procedures" (10).

As originally written, the act generally could not be used to withhold or withdraw life-sustaining procedures from a patient in a persistent vegetative state or irreversible coma because death rarely was imminent if life-sustaining procedures were used. Increasingly in the past several years, hospitals have faced requests from physicians and family members of these types of patients to withhold or withdraw life-sustaining procedures. With the act as the only existing statutory authorization for these decisions, physicians and families had to be advised that the act did not extend to these patients, nor did it afford immunity to physicians who implemented such decisions. Due to the act's limitations and the absence of any reported Texas cases on the authority to withhold or withdraw treatment from patients for whom death was not imminent if life sustaining procedures were continued, treatment decisions frequently were not consistent with accepted medical and ethical standards (11).

SB 1785 changed the definition of "terminal condition" to mean "an incurable *or irreversible* condition caused by injury, disease, or illness, which, *without* the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of the patient" (12). It also changes the definition of "life-sustaining procedures" to mean that either death must be imminent regardless of whether such procedures are used or, as added by SB 1785, death "*will result within a relatively short time without application of such procedures*" (13).

With the SB 1785 changes, the act's procedures may be used to withhold or withdraw treatment if:

1. The patient has an incurable or irreversible condition caused by injury, disease, or illness;
2. Death will result without the application of life-sustaining procedures, and application of life-sustaining procedures only postpones or artificially prolongs the moment of death; and
3. Death is imminent regardless of whether life-sustaining procedures are used *or* death will result within a relatively short time without life-sustaining procedures.

PATIENT COMPETENCY

Although the act referred to "competent" and "incompetent" adults, it did not define those terms before the enactment of SB 1785. Some physicians had questioned whether these terms required a judicial or legal determination of competency. SB 1785 defines "competent" as "possessing the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, in-

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cluding the significant benefits and harms of and reasonable alternatives to any proposed treatment decision" (14). "Incompetent" means lacking those abilities (15). SB 1785 clarifies that a physician is to assess competency, and judicial review is not required.

WITNESSES

Lastly, SB 1785 deletes the prohibition on employees of a health care facility in which the patient is residing from serving as witnesses to a Natural Death Act directive or treatment decision (16). Many health care facilities had experienced significant difficulty in locating two witnesses who satisfied the strict witness requirements in the statute, and visitors or members of other patients' families were sometimes the only persons available to serve as witnesses. The amendments allow an employee of a health facility to serve as a witness to a directive or treatment decision except when "the employee is providing direct patient care to the declarant or is directly involved in the financial affairs of the facility" (17). This change should allow employees such as social workers or persons involved in pastoral care to serve as witnesses.

FUTURE LEGISLATION

SB 1785 did not address two other major issues associated with the Natural Death Act, which may be the subject of future legislation. The definition of life-sustaining procedures does not specifically include or exclude nutrition and hydration (18). Although a 1987 Texas Attorney General Opinion provided that nutrition and hydration may qualify as life-sustaining procedures in certain cases, the failure of the act to address this issue leaves uncertainty among health care providers (19). Consequently, some providers require a court order before agreeing to withhold or withdraw nutrition or hydration, particularly in the case of minors. The other area that needs to be addressed in the future is whether, without guardianship proceedings or other judicial intervention, life-sustaining procedures may be withheld or withdrawn from an incompetent, terminally ill patient who has not executed a Natural Death Act directive and has no family or legal guardian.

Durable power of attorney for health care—House Bill 2098

The Natural Death Act addresses only treatment decisions for patients who are terminal. It does not address decision making for other types of health care decisions. HB 2098 establishes detailed procedures for use of a durable power of attorney specifically for health care decisions (20). Under HB 2098, a competent adult (or principal), using a written power of attorney, may designate another adult as his agent to make health care decisions if the principal ever lacks the capacity to make health care decisions for himself (21).

SCOPE

The scope of the bill is broad, with a "health care decision" defined as "consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition" (22). The bill does not allow an agent to consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, abortion, or neglect of the principal through the omission of care primarily intended to provide for the comfort of the principal (23). However, the bill does empower an agent to discontinue life-sustaining procedures at the agent's discretion. Unlike the Natural Death Act, HB 2098 does not restrict decision-making to situations in which the patient's death is imminent or will result shortly without life-sustaining procedures, or to situations in which two physicians certify that the patient has a terminal condition. The agent acts as a surrogate decision maker for all health care matters when the patient lacks the capacity to do so (24).

EXECUTION OF DOCUMENT

Designating an agent requires execution of a written power of attorney in substantially the same form as the sample durable power of attorney set forth in HB 2098 (25). The form is designed so it can be executed without the services of an attorney, and it is effective indefinitely unless otherwise specified (26). The principal's health or residential care provider may not serve as an agent, nor may an employee of a provider unless the employee is a relative of the principal (27).

The durable power of attorney must be signed in the presence of at least two witnesses, neither of whom may be the principal's health or residential care provider or the provider's employee, the agent, the principal's spouse or heir, or a person entitled to any part of the principal's estate or who has a claim against the estate (28). Witnesses are required to affirm (at the time the power of attorney is signed) that the principal appeared to be of sound mind, that he stated in the witnesses' presence that he was aware of the nature of the document and that he was signing it voluntarily and free from duress, and that he requested that the witnesses serve as witnesses (29). If the principal is physically unable to sign the document, another person may sign it in the principal's presence and at the principal's express direction (30).

DUTY TO COMPLY

The agent's authority begins only when the principal's attending physician certifies in writing and files this certification in the medical record that based on the physician's reasonable medical judgment, the principal lacks the capacity to make health care decisions (31). "Capacity" is defined as "the ability to understand and appreciate the nature and consequences of a health care decision, including the significant benefits and harms of, and reasonable alternatives to, any proposed health care" (32).

HB 2098 requires that providers and their employees who know of the existence of a power of attorney must follow the agent's directives to the extent they are consistent with the desires of the principal, the provisions of the statute, and the power of attorney (33). Although this appears to require the provider to review the durable power of attorney document and be familiar with the statute, HB 2098 specifically provides that the attending physician does not have a duty to verify that the agent's directive is consistent with the principal's wishes or religious or moral beliefs (34).

In the event that the agent directs a nonphysician provider

to implement or change a certain treatment decision (rather than communicating directly with the physician), HB 2098 provides that the nonphysician provider is not required to act contrary to a physician's order (35).

REVOCATION

A principal may revoke a durable power of attorney by oral or written notification to the agent or any licensed or certified health or residential care provider, or by any other act indicating the intent to revoke (36). The power of attorney also can be revoked by execution of a subsequent power of attorney or divorce of the principal and spouse, where the spouse was designated as the agent (37). Revocation is effective regardless of the principal's mental state, competency, or capacity to make health care decisions (38). HB 2098 requires that a licensed or certified health or residential care provider who is notified of revocation immediately record the revocation in the patient's records and notify the agent and any known providers currently responsible for the principal's care of the revocation (39).

IMMUNITY

An attending physician, other health or residential care provider, or person acting as an agent for or under the physician's or provider's control is not subject to criminal or civil liability and has not engaged in unprofessional conduct if:

1. The act or omission is done in good faith under the terms of the durable power of attorney, the directives of the agent, and the statute; and
2. The act or omission does not constitute a failure to exercise due care in the provision of health care services (40).

Therefore, if the act or omission by the physician or other health care provider constitutes negligence, the immunity provisions would not apply.

HB 2098 also provides that a physician has not engaged in unprofessional conduct if he fails to follow an agent's directive or power of attorney when he has not been provided with a copy of the power of attorney or has no knowledge of the agent's directive (41). Additionally, a physician has not engaged in unprofessional conduct by acting pursuant to an agent's directive when the physician did not know that the power of attorney had expired or had been revoked (42).

CONFLICT

If there is an agent *and* a legal guardian for the patient, HB 2098 provides that the probate court will determine whether to suspend or revoke the authority of the agent (43). Until the probate court makes this determination, the guardian has the sole authority to make any health care decisions, unless the probate court orders otherwise (44). If a petition for appointment of a guardian is filed, the probate court again will determine whether to suspend or revoke the authority of the agent (45). Until a guardian is appointed, however, the agent retains his power to make health care decisions, unless the probate court orders otherwise (46).

HB 2098 provides that in the event of a conflict between a durable power of attorney and a Natural Death Act directive or treatment decision, the instrument executed most recently controls (47). Further, a physician who withholds or withdraws life-sustaining procedures from a principal with a terminal condition and who does so pursuant to an agent's directive is not also required to comply with the procedures in the Natural Death Act (48).

Summary

These recent legislative changes should assist physicians in implementing appropriate health care decisions by patients and their families. The Natural Death Act amendments authorize the withholding and withdrawal of life-sustaining procedures from patients with incurable or irreversible conditions if death will result within a relatively short time without use of such procedures. The amendments are effective Sept 1, 1989, and apply to directives executed on or after that date.

The durable power of attorney bill, effective June 14, 1989, provides a comprehensive method for allowing decision making by a surrogate. Education of the public and advance planning by principals are needed for it to be effective. Because HB 2098 requires advance execution of the power of attorney, in all likelihood most decisions to withhold or withdraw life-sustaining procedures from patients with a terminal condition will continue to be made using the procedures set forth in the Natural Death Act.

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4. Id § 4B, § 4C.
5. Id § 4D.
6. Id § 6. As a side note, an amendment to Section 22.04 of the Texas Penal Code expands the criminal offense of injury to a child or elderly person to include injury to an invalid individual. Tex SB 1154, 71st Leg, 1st Sess § 1 (1989); Tex Pen Code § 22.04 (1989). An omission by an individual who has assumed responsibility for an invalid's medical care which causes injury constitutes an offense. It is a defense to prosecution if the omission consisted of reasonable medical care under the direction of a licensed physician. Although apparently this amendment had nothing to do with the Natural Death Act, its potential application to the withholding or withdrawal of treatment in cases not covered by the act may cause more physicians to follow the act's procedures so they can be assured of statutory immunity.
7. Id § 2(4), (6), (7).
8. Id § 2(4) (emphasis added).
9. See Uniform Rights of the Terminally Ill Act § 1, comment 9B ULA 609 (1988).
10. Id.
11. Text on Care, Management of Persistent Vegetative State Cited, Medical Ethics Advisor, Aug 1988, at 111 (giving complete text of paper "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient"); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 6 (1983); Council on Ethical and Judicial Affairs of the American Medical Association, Current Opinions § 2.20 (1989).
12. Art 4590h, § 2(7), as amended by Tex SB 1785 § 1 (1989) (emphasis added).

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13. Id § 2(4), as amended by Tex SB 1785 § 1 (1989) (emphasis added).
14. Id § 2(8), as amended by Tex SB 1785 § 1 (1989).
15. Id § 2(9), as amended by Tex SB 1785 § 1 (1989).
16. Id § 3(a), as amended by Tex SB 1785 § 2 (1989).
17. Id § 3(a)(2), as amended by Tex SB 1785 § 2 (1989).
18. Id § 2(4).
19. Op Tex Att'y Gen No. JM-837 (1987). This is consistent with the AMA's position that life-prolonging medical treatment that may be discontinued includes artificially or technologically supplied nutrition and hydration. Council on Ethical and Judicial Affairs of the American Medical Association, Current Opinions § 2.20 (1989).
20. See Tex Prob Code Ann § 36A (1980) (existing durable power of attorney provision does not specify whether includes health care decisions).
21. Tex HB 2098, § 2.
22. Id § 1(6).
23. Id § 2(f).
24. Id § 2(a)–(b).
25. Id § 15, § 16.
26. Id § 2(g), § 15.
27. Id § 3.
28. Id § 4(a)–(b).
29. Id § 4(c).
30. Id § 4(d).
31. Id § 2(b).
32. Id § 1(4).
33. Id § 8(a).
34. Id § 8(b).
35. Id § 8(d).
36. Id § 5(a)(1).
37. Id § 5(a)(2)-(3).
38. Id § 5(a)(1).
39. Id § 5(b).
40. Id § 10(b).
41. Id § 10(c)(1).
42. Id § 10(c)(2).
43. Id § 6(a).
44. Id § 6(c).
45. Id § 6(a).
46. Id § 6(c).
47. Id § 12.
48. Id

Texas Natural Death Act

Guidelines and Directives

The Texas Legislature has enacted the Texas Natural Death Act* which authorizes use of written and oral directives in accordance with the guidelines set out below.

Accompanies TMH Forms 21-0023

Directive to Physicians
For Persons 18 Years of Age and Over

Directive to Physicians
For Persons Under 18 Years of Age

Directive to Physicians
For Incompetent Patients

Guidelines for Signers

The DIRECTIVE allows you to instruct your physician not to use artificial methods to extend the natural process of dying.

Before signing the DIRECTIVE, you may ask advice from anyone you wish, including your attorney.

If you sign the DIRECTIVE, talk it over with your physician and ask that it be made part of your medical record. If you have signed a written DIRECTIVE of which your doctor is unaware and if you become physically or mentally unable to inform your doctor of its existence, another person may do so.

The DIRECTIVE must be WITNESSED by two adults who (1) are not related to you by blood or marriage, (2) are not mentioned in your will, and (3) would have no claim on your estate.

The DIRECTIVE may NOT BE WITNESSED by your physician or by anyone working for your physician. If you are in a health care facility at the time you sign the DIRECTIVE, none of its patients may be a witness, and none of its employees may be a witness if they are involved in providing direct patient care to you, or are directly involved in the financial affairs of the health care facility.

If you are at least 18 years old, of sound mind, and acting on your own free will in the presence of two qualified witnesses, you may sign a DIRECTIVE TO PHYSICIANS concerning your own care.

If a qualified patient is under 18 years of age, any of the following persons may execute a DIRECTIVE on behalf of the patient: (1) the patient's spouse, if he/she is an adult; (2) the patient's parents; or (3) the patient's legal guardian.

However, the desires of a competent, qualified patient who is under 18 years of age shall always supersede a DIRECTIVE executed on his/her behalf.

No one may force you to sign the DIRECTIVE. No one may deny you insurance or health care services because you have chosen not to sign it. If you do sign the DIRECTIVE, it will not affect your insurance or any other rights you may have to accept or reject medical treatment.

Your physician will be guided by the DIRECTIVE only (1) if he/she is satisfied that the DIRECTIVE is valid, and (2) if he/she and another doctor have certified your condition as terminal.

If your attending physician chooses not to follow the DIRECTIVE, he/she must make a reasonable effort to transfer responsibility for your care to another physician.

The DIRECTIVE is valid until it is revoked in accordance with Section 4 of the Texas Natural Death Act.

You may revoke the DIRECTIVE at any time, even in the final stages of a terminal illness. If you revoke the DIRECTIVE, be sure your physician is told of your decision. If you change your mind after executing a DIRECTIVE, your expressed desire to receive life-sustaining treatment will at all times supersede the effect of a DIRECTIVE.

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* *Article 4590h V.A.T.S.*

21-0023
1/90

Summary and Guidelines for Physicians

Introduction—A person who is at least 18 years of age and of sound mind may sign a DIRECTIVE TO PHYSICIANS as provided by the Texas Natural Death Act. This Act permits a person who meets certain qualifications to give legal effect to his/her wishes to avoid artificial prolongation of the dying process. It also imposes certain obligations—and provides certain protections—for a physician dealing with a person presenting a DIRECTIVE. The Act also enables certain persons to execute a DIRECTIVE on behalf of a qualified patient who is under 18 years of age.

Signature and Witnesses—To be effective, a written DIRECTIVE must be signed by the patient, witnessed by two persons who are not related to the patient by blood or marriage, are not mentioned in his/her will, are not potential claimants to his/her estate, and are not involved in the patient's medical care. Thus, the DIRECTIVE cannot be witnessed by you or any of your employees or any other physician or his/her employees. It may be witnessed by the employees of any health facility where the declarant is a patient, but only if those employees are not involved in providing direct patient care to the declarant, or are not directly involved in the financial affairs of the health facility. Likewise, it may not be witnessed by patients of any health facility where the declarant is a patient.

The DIRECTIVE is effective until it is revoked. A person signing a DIRECTIVE should, if possible, present the document to his/her physician so that it can be made part of his/her current medical records.

Effect of a Directive

Upon receipt of a DIRECTIVE from a patient (qualified or unqualified) the attending physician must determine that the DIRECTIVE meets legal requirements. Under the Act a "qualified patient" is a person diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

A terminal condition means an incurable or irreversible condition caused by injury, disease, or illness, which, without the use of "life-sustaining procedures", would, within reasonable medical judgment, produce death, and where the use of life-sustaining procedures serves only to postpone the moment of the patient's death.

If the physician does not choose to carry out the DIRECTIVE of a qualified patient, he/she must make a reasonable effort to transfer the patient to another physician. No physician, health care facility, or other health care professional will be civilly or criminally liable for failure to carry out a DIRECTIVE if the person involved had no knowledge of the DIRECTIVE.

The physician who carries out the DIRECTIVE is protected from civil and criminal liability, unless he/she acts negligently.

The DIRECTIVE has no operative effect until two physicians determine the patient has a terminal condition and that death is imminent whether or not "life sustaining procedures" are utilized or will result within a relatively short time without application of such procedures. This fact is noted in the patient's medical records. "Life-sustaining procedures" include mechanical or other "artificial means" which would sustain vital functions of the patient but would only postpone the moment of death. These do not include medications or procedures deemed necessary to provide comfort or care or alleviate pain.

The DIRECTIVE is invalid and has no effect if the patient is pregnant at the time it is to be carried out.

Revocation—A patient may revoke the DIRECTIVE at any time. Should you receive such revocation from or on behalf of a patient who has previously signed a DIRECTIVE, enter that information promptly and prominently in the patient's current medical record.

Summary—Withholding "life-sustaining procedures" in compliance with a DIRECTIVE is not euthanasia or "mercy killing." The DIRECTIVE is merely a method recognized under Texas law by which a physician may respect a patient's instructions to permit an imminent death to proceed naturally.

Directive to Physicians

For Incompetent Patients

For instructions on use of this form, please see Texas Natural Death Act Guidelines and Directives (Form 21-0023)

DIRECTIVE made this _____ day _____ (month, year).

On behalf of _____, a qualified patient under the Texas Natural Death Act who is incompetent, I/we _____, being of sound mind, willfully and voluntarily make known my/our desire that his/her life not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time the patient whose name appears above should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of "life-sustaining procedures" would serve only to artificially prolong the moment of his/her death and where his/her attending physician determines that his/her death is imminent or will result within a relatively short time without application of "life-sustaining procedures", I/we direct that such procedures be withheld or withdrawn, and that he/she be permitted to die naturally.

2. On behalf of the said patient, it is my/our intention that this DIRECTIVE shall be honored by his/her physicians as the final expression of my/our legal right to refuse medical or surgical treatment on behalf of the said patient and to accept the consequences from such refusal.

3. If she has been diagnosed as pregnant and that diagnosis is known to her physician, this DIRECTIVE shall have no force or effect during the course of her pregnancy.

4. This DIRECTIVE shall be in effect until it is revoked. I/we understand that my/our authority to execute this DIRECTIVE on behalf of the above-named patient expires if this patient becomes competent.

5. I/we understand the full import of this DIRECTIVE and I/we am/are emotionally and mentally competent to make this DIRECTIVE.

6. I/we understand that the desire of the above-named patient, if mentally competent, to receive life-sustaining treatment shall at all times supersede the effect of this DIRECTIVE.

Signed _____

City, County, and State of Residence _____

Indicate relationship to patient _____ Legal Guardian _____ Spouse _____ Adult Children

_____ Parents _____ Siblings

Two witnesses must sign the DIRECTIVE in the spaces provided below.

I am not related to the declarant by blood or marriage; nor am I the attending physician of the declarant or an employee of the attending physician; nor am I a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.

Witness _____

Witness _____

Directive to Physicians

For Persons Under 18 Years of Age

For instructions on use of this form, please see Texas Natural Death Act Guidelines and Directives (Form 21-0023)

DIRECTIVE made this _____ day _____ (month, year).

On behalf of _____, a qualified patient under the Texas Natural Death Act who is under 18 years of age, I/we _____, being of sound mind, willfully and voluntarily make known my/our desire that his/her life not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time the patient whose name appears above should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of "life-sustaining procedures" would serve only to artificially prolong the moment of his/her death and where his/her attending physician determines that his/her death is imminent or will result within a relatively short time without application of "life-sustaining procedures", I/we direct that such procedures be withheld or withdrawn, and that he/she be permitted to die naturally.

2. On behalf of the said patient, it is my/our intention that this DIRECTIVE shall be honored by his/her physicians as the final expression of my/our legal right to refuse medical or surgical treatment on behalf of the said patient and to accept the consequences from such refusal.

3. If she has been diagnosed as pregnant and that diagnosis is known to her physician, this DIRECTIVE shall have no force or effect during the course of her pregnancy.

4. This DIRECTIVE shall be in effect until it is revoked. I/we understand that my/our authority to execute this DIRECTIVE on behalf of the above-named patient expires on his/her 18th birthday.

5. I/we understand the full import of this DIRECTIVE and I/we am/are emotionally and mentally competent to make this DIRECTIVE.

6. I/we understand that the desire of the above-named patient, if mentally competent, to receive life-sustaining treatment shall at all times supersede the effect of this DIRECTIVE.

Signed _____

City, County, and State of Residence _____

Indicate relationship to patient _____ Spouse _____ Parents _____ Legal Guardian

Two witnesses must sign the DIRECTIVE in the spaces provided below.

I am not related to the declarant by blood or marriage; nor am I the attending physician of the declarant or an employee of the attending physician; nor am I a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.

Witness _____

Witness _____

For instructions on use of this form, please see Texas Natural Death Act Guidelines and Directives (Form 21-0023)

Directive to Physicians

For Persons 18 Years of Age and Over

DIRECTIVE made this _____ day _____ (month, year).

I _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of "life-sustaining procedures" would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent or will result within a relatively short time without application of "life-sustaining procedures", I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such "life-sustaining procedures", it is my intention that this DIRECTIVE shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this DIRECTIVE shall have no force or effect during the course of my pregnancy.

4. This DIRECTIVE shall be in effect until it is revoked.

5. I understand the full import of this DIRECTIVE and I am emotionally and mentally competent to make this DIRECTIVE.

6. I understand that I may revoke this DIRECTIVE at any time.

7. I understand that Texas law allows me to designate another person to make a treatment decision for me if I should become comatose, incompetent, or otherwise mentally or physically incapable of communication. I hereby designate

   _____, who resides at _____
   (print or type name)

   to make such a treatment decision for me if I should become incapable of communicating with my physician. If the person I have named above is unable to act on my behalf, I authorize the following person to do so:

   Name _____

   Address _____

   I have discussed my wishes with these persons and trust their judgment.

8. I understand that if I become incapable of communication, my physician will comply with this DIRECTIVE unless I have designated another person to make a treatment decision for me, or unless my physician believes this DIRECTIVE no longer reflects my wishes.

Signed _____

City, County, and State of Residence _____

Two witnesses must sign the DIRECTIVE in the spaces provided below.

I am not related to the declarant by blood or marriage; nor am I the attending physician of the declarant or an employee of the attending physician; nor am I a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.

Witness _____

Witness _____

This form is produced pursuant to a law enacted by the Texas Legislature effective June 14, 1989. (Tex. Rev. Civ. Stat. art. 4590h-i) (Vernon's Supp. 1989)

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the capacity to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent durable power of attorney for health care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent;

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DESIGNATION OF HEALTH CARE AGENT

I, _____, appoint

Name:_____

Address:_____

_____ Phone:_____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care takes effect if I become unable to make my own health care decision and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

DESIGNATION OF ALTERNATE AGENT

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name:_____

Address:_____

_____ Phone:_____

B. Second Alternate Agent

Name:_____

Address:_____

_____ Phone:_____

The original of this document is kept at _____

_____

The following individuals or institutions have signed copies:

Name:_____

Address:_____

_____

Name:_____

Address:_____

_____

DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this durable power of attorney for health care on the

_____ day of _____, 19_____ at _____
(address)

_____ .
(City and State)

_____
(Signature)

_____
(Print Name)

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this durable power of attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed as agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature: _____

Print Name: _____ Date: _____

Address: _____

Witness Signature: _____

Print Name: _____ Date: _____

Address: _____

BIBLIOGRAPHIES AND AUDIOVISUAL GUIDES

Annotated Bibliography by Objective

Multigenerational Practice: Concepts, Methods, and Applications in Elder-Focused Practice

Bibliography on Aging and Family Concerns -- N. L. Wilson

Caring for Memory-Impaired Elders: Family Reading -- Duke University Medical Center

Biomedical Research in Alzheimer's Disease: A Selected List of Recent Publications -- Alzheimer's Association

Audiovisual Resource List

Resource Materials for Undergraduate Social Work Educators in Elder Care--N. R. Hooyman

ANNOTATED BIBLIOGRAPHY BY MODEL FIELD INSTRUCTION OBJECTIVE

OBJECTIVE I:

Chinen, A.B. In the Ever After: Fairy Tales and the Second Half of Life, Wilmette, IL: Chiron Publications, 1989.

This book is a multicultural assembly of fairy tales featuring ordinary older people as protagonist and reflecting mankind in general. The author presents each tale followed by his own interpretations of the psychological and spiritual aspects of growing old. ISBN 0-933029-41-1.

Hepworth, D.H. and Larsen, J.A. Direct Social Work Practice: Theory and Skills, third edition, Belmont, CA: Wadsworth Publishing Company, 1990.

This book targets those in the academic setting such as faculty members and undergraduate and graduate students. This book covers a myriad of topics including: an overview of social work, environmental and functional assessments, relationship-building skills, planning and implementation, and termination and evaluation. Chapter 5 focuses on skills essential to building effective working relationships with clients emphasizing empathic and authentic communications. ISBN 0-534-12366-X

Sennett, Dorothy, ed. Full Measure: Modern Short Stories on Aging, St. Paul, Minn.: Graywolf Press, 1988.

A collection of twenty-three stories about aging written by contemporary authors, including Alice Walker, Ruth Prawer Jhabvala, Elizabeth Jolley, Jorge Luis Borges, and others.

Sennett, Dorothy, ed. Vital Signs: International Stories on Aging, St. Paul, Minn.: Graywolf Press, 1992.

This book is a sequel to collection of stories on aging, Full Measure: Modern Short Stories on Aging. Twenty-one stories are featured each with its own unique cultural and societal context. Even with the diverse context, the stories illustrates the universality of the aging experience: the capacity of to survive, the fight to maintain dignity and self-worth, the stirring of desire and longing, the feelings of alienation and loss, and the pain experienced from lost dreams, physical decline, and despair.

OBJECTIVE II:

Bould, D., Sanborn, B., Reif L. Eighty-Five Plus: The Oldest Old, Wadsworth Publishing Company, Belmont, CA, 1989

This book focuses on the challenges and issues involved in adequately serving needs of the oldest old population and reducing the risk of dependence. Current and projected demographic characteristics of this subpopulation are provided as well as are comparisons of this group with other elderly age groups. Health issues are reviewed with information on possibilities for restoring and preventing functional ability among the oldest old. The personal coping and social familial resources of the 85+ population are discussed including the importance of such resources in achieving independence and interdependence. Also examined are the economic resources of this group as well as their special financial problems related to medical care and widowhood. Also emphasized, is the special role of the caregiver for the oldest old; caregiver burden, increasing age of caregivers, and the need for respite care are discussed. The chapter on formal services reviews the range of services available to the elderly giving special attention to the need for services among the 85+ group. The current system is reviewed and gaps are identified. Finally, the last chapter describes recent trends in the organization and financing of services and analyzes the impact of these trends on the oldest old.

OBJECTIVE III:

Mangen, D.J. and Peterson, W.A. Research Instruments in Social Gerontology: Social Roles and Social Participation, Vol. 2, Minneapolis, MN: University of Minnesota Press, 1982.

This book contains relevant scales that are useful for biopsychosocial assessment. The scales measure social participation roles, dyadic relations, parent-child relations, kinship relations, work and retirement, socioeconomic status and poverty, religiosity, voluntary associations, leisure activities, friends, neighbors, and confidants. ISBN 0-8166-1096-7.

OBJECTIVE IV:

American Association of Retired Person & American Bar Association. Health Care Power of Attorney, 1990.

The first part of this booklet uses a question-answer format explaining: what the Health Care Power of Attorney is , why is it useful, its validity from state to state, and termination of it. The second part contains a sample of the document and a detailed explanation of each section. ISBN 0-89707-470-X.

Beaver, M. L. and Miller, D.A. Clinical Social Work Practice with the Elderly: Primary, Secondary, and Tertiary Intervention, Second Edition. Wadsworth Publishing, Belmont, 1992.

This book is intended for use as a primary textbook for the education of professional clinical practitioners to work in the field of aging especially social work education. Co-authored by two social work faculty members from the University of Pittsburgh, the textbook contains eleven chapters beginning with "The Experience of Aging " (i.e., biopsychosocial changes) and extending through the final chapter on timely "Practice Issues" (i.e., social policy issues impacting practice such as Economic and Health Care Concerns). The other nine chapters focus on the authors' examination of social work roles and intervention with the elderly on primary, secondary, and tertiary levels of intervention. Case examples are used extensively to illustrate the discussion of social work practice with the elderly along a continuum of functional abilities: the well-elderly up to the functionally impaired elderly. The diverse roles a social worker may assume (advocate, broker, counselor, educator, etc.) are examined with each client group. The use of individual, family, and group work approaches at all levels of intervention is also explored. The authors provide a generally comprehensive overview of social work practice with both community-dwelling and institutionalized elderly with references for more in-depth coverage of specific issues.

Knight, B. Psychotherapy with Older Adults, Newbury Park, CA: Sage Publications, Inc., 1986.

This book focuses on the nature of therapy with older adults exploring the need for special knowledge in such content areas as chronic illness and disability; death and dying; marriage, love and sex; the crisis of growing older; and the role of ethnic identity in late life. Special attention is given to the context of the relationship between younger therapist and older client and the distortion of that relationship on each side by unresolved psychological conflicts with significant others of similar age. ISBN 0-8039-2633-2 cloth,ISBN 0-8039-3534-X paper.

OBJECTIVE VII:
Texas Consortium of Geriatric Education Centers. Resource Guide: A Learning Module in Geriatrics, Baylor College of Medicine, 1990.

This resource guide consists of eight modules. The topics covered include: sociological, psychological, and biological aspects of aging, health assessment, disease processes, health promotion, pharmacology, and organizing and conducting better teaching in gerontology and geriatrics.

OBJECTIVE X:

American Association of Retired Persons. AARP Publications and A/V Programs: The Complete Collection, AARP, 1992.

A complete listing of AARP's publications and audiovisual programs covering topics such as long-term care, family issues, home and community, employment and retirement, legislation and public policy, and education and research. ISBN 1045-506X.

Barusch, A.S. Elder Care, Newbury Park, CA: Sage Publications, Inc., 1991.

The book is divided into two parts. Part I offers detailed guidelines for those interested in establishing a short-term training program for family caregivers which includes: a framework of the dynamics of caregiving, designing and implementing caregiver support program, and evaluating caregiver programs. Part II presents background material and exercises that can be used either by trainers or by those personally involved in caregiving including: normal aging, family relationships, community services and resources, legal and financial concerns, managing medications and ensuing home safety,and grief and dying. ISBN 0-8039-4227-3 cloth, ISBN 0-8039-4185-4 paper.

Bumagin, V.E. and Hirm, K.F. Helping the Aging Family: A Guide for Professionals, Glenview, IL: Scott, Foresman Professional Books on Aging, 1990.

This complete handbook is written for professionals of all disciplines who work with elderly persons and their families. Part One describes the early stages of intervention and the interactive approach; essential interviewing techniques; assessment guidelines; and the principles of counseling with aging families. Part two gives techniques for ongoing work with physical decline, socially distressing behavior, cognitive loss, bereavement, and depression in the elderly. Part three offers strategies for sensitive termination of services and ways to evaluate the success of interventions. ISBN 0-673-24938-7.

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Nancy L. Wilson, M.A.
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Taking Care of Your Aging Family Members: A Practical Guide by Nancy Hooyman and Wendy Lustbader, Free Press, 1986.

The Unfinished Business of Living by Elwood Chapman, Crisp Publications, 1988.

How to Care for Your Parents, A Handbook for Adult Children by Nora Jean Levin: Storm King Press, 1987.

The Healing Family: The Simonton Approach for Families Facing Illness by Stephanie Matthews Simonton & Robert L. Shook, Bantam, New York, NY, 1984.

Helping Your Aging Parents: A Practical Guide for Adult Children by James Halpern, McGraw-Hill, New York, NY, 1987.

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The Other Generation Gap: The Middle-Aged and their Aging Parents by Stephen Z. Cohen and Bruce M. Gans, New Century, Piscataway, NJ, 1978.

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The Home Health Care Solution: A Complete Consumer Guide by Janet Zhun Nassif, Harper & Row, New York, NY, 1985.

Managing Incontinence: A Guide to Living with the Loss of Bladder Control edited by Cheryle B. Gartley, Jameson Books, Ottawa, IL, 1985.

Taking Care: A Self-Help Guide for Coping with an Elderly, Chronically Ill, or Disabled Relative by Jill Watt and Ann Calder, Self-Counsel Press, Seattle, WA, 1986.

Nancy L. Wilson, M.A.
Huffington Center on Aging, Baylor College of Medicine

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Safety for Older Consumers: Home Safety Checklist, U.S. Consumer Product Safety Commission, Washington, D.C. 20207.

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Family Involvement in the Nursing Home Experience by Betty McMeekin, North Texas State University Press, Denton, Tx.

Choosing a Nursing Home, Seth B. Goldsmith, New York, Prentice Hall Press, 1990.

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ALZHEIMER'S DISEASE

The following books and pamphlets are available at the Houston Chapter office of the Alzheimer's Association, 6161 Savoy, Suite 240, Houston, Texas 77036, 266-6400 or by mail:

Care of Alzheimer's Patients: A Manual for Nursing Home Staff by Lisa Gwyther: $6.56 at the Chapter office, $7.56 by mail.

Grandpa Doesn't Know It's Me by Donna Guthrie: Human Sciences Press, 1986, $5.40 at the Chapter office, $6.40 by mail.

The 36 Hour Day by Nancy Mace and Peter Rabins: Johns Hopkins University Press, 1982, $7.56 at the Chapter office, $8.56 by mail.

Understanding Alzheimer's Disease (What it is; How to cope with it; Future directions) by The Alzheimer's Association: Charles Scribner's Sons, 1988, $10.80 at the Chapter office, $12.80 by mail.

OTHER INFORMATION

There are many useful resources available through the American Association of Retired Persons (AARP). The following is a partial listing of the resources that you can request at the addresses listed below:

DUKE UNIVERSITY MEDICAL CENTER

FAMILY SUPPORT PROGRAM
CENTER FOR THE STUDY OF AGING AND HUMAN DEVELOPMENT
Box 3600 • Durham, North Carolina 27710 • Telephone (919) 684-2328
Toll Free in N.C. Only (800) 672-4213

December 1990
Lisa Gwyther, ACSW

CARING FOR MEMORY-IMPAIRED ELDERS: FAMILY READING

AAHA. The Nursing Home and You: Partners in Caring for a Relative with Alzheimer's Disease. Available from Triad Alzheimer's Association, P.O. Box 15622, Winston-Salem, NC 27113. $4.50. 32 page paperback.

AARP. Coping and Caring: Living with Alzheimer's Disease. 1986. Free single copies from Fulfillment, 1909 K. St. NW, Washington, DC 20049.

AARP. Miles Away and Still Caring: A Guide for Long Distance Caregivers. 1909 K. St. NW, Washington, DC 20049.

Alzheimer's Association. Understanding Alzheimer's Disease: What It Is, How To Cope With It, Future Directions. 1988. Edited by Miriam K. Aronson, Ed.D. New York: Charles Scribner's Sons. Available from Alzheimer's Association chapters. (Ask about, "Just the Facts" and Topical brochure series as well.)

Alzheimer's Association, Atlanta. Guide to Home Safety for Caregivers of Persons with Alzheimer's Disease. 1990. 3120 Raymond Dr., Atlanta, GA 30340. (404) 451-1300. $5.50 + 5% sales tax.

Alzheimer's Association, Eastern Massachusetts. Family Care Guide. 1988. One Kendal Square, Bldg 600, Cambridge, MA 02139. $10.00 for members, $12.50 non-members (add $2.00 for postage/handling).

Ballard, Edna. Managing Grief and Bereavement. A guide for families and professionals caring for memory-impaired adults. Duke Family Support Program, Box 3600 DUMC, Durham, NC 27710. 1989. $3.00.

Brunette, M. and Fowler, M. The Yankee Caregiver...If You Care For Someone with Alzheimer's. 1988. Alzheimer's Center. 152 Dresden Ave., Gardiner, ME 04345.

Bryan, Jessica. Love is Ageless: Stories about Alzheimer's Disease. Serala Press, P.O. Box 3876, Oakland, CA 94609. $9.95 paperback.

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Cohen, D. & Eisdorfer, C. The Loss of Self. 1986. A family resource for the care of Alzheimer's Disease and related disorders. New York: Norton & Co.

Davis, Robert. My Journey into Alzheimer's Disease. Tyndale House, Wheaton, IL. 1989. $5.95 paperback.

Doernberg, M. Stolen Mind. 1989. Paperback. Chapel Hill,NC: Algonquin Press. $8.95. (Available from some Alzheimer's Association chapters.)

Greenberg, V.E. Your Best is Good Enough: Aging Parents and Your Emotions. 1989. Lexington, MA. Lexington Books. $16.95.

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Honel, Rosalie. Journey with Grandpa. 1988. Baltimore, MD: The Johns Hopkins Press. $16.95.

How to Hire Helpers: A Guide for Elders and Their Families. Church Council of Greater Seattle, 4759 15th NE, Seattle, WA 98105. (206) 525-1213.

Kushner, Harold. When Bad Things Happen to Good People. 1982. Paperback. Available in popular bookstores. Reassuring, compassionate.

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Manning, Doug. When Love Gets Tough: The Nursing Home Decision. 1985. (Revised paperback). In-Sight Books, Inc., Drawer 2058, Hereford, TX 79045. A minister reflects on his decision to place his mother in a nursing home.

Murphey, Cecil. Day to Day: Spiritual Help When Someone you Love has Alzheimer's. Westminister Press. Philadelphia, PA. 1988. $8.95.

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The Caregiver. Newsletter of the Duke Family Support Program. $10/year subscription. Box 3600 DUMC, Durham, NC 27710.

BENJAMIN B. GREEN-FIELD

NATIONAL ALZHEIMER'S LIBRARY AND RESOURCE CENTER

BIOMEDICAL RESEARCH IN ALZHEIMER'S DISEASE

A selected list of recent publications

Prepared by
Vicki Bloom Bakowski, Associate Director
Benjamin B. Green-Field
National Alzheimer's Library and Resource Center
and
Reviewed by
Creighton Phelps, Ph.D., Sr. Vice-President
Division of Medical & Scientific Affairs
Alzheimer's Association

This bibliography is geared to families and caregivers of Alzheimer's patients, and anyone interested in the latest developments in Alzheimer's biomedical research. Topics include basic and clinical advances in causes, diagnosis, risk factors, epidemiology, genetics, and treatment. The chosen articles review or capsulize current thinking and research emphasis, and can be readily found at many libraries. This selective listing does not constitute endorsement of the material or its contents.

To obtain a copy of an item listed, first check for availability at your local library. Copies of articles may also be received by contacting the Benjamin B. Green-Field Library. To expedite retrieval at most libraries, articles are arranged alphabetically by periodical name within broad topics.

For a bibliography of articles on other subjects, contact the Benjamin B. Green-Field Library.

ALZHEIMER'S

919 North Michigan Avenue
Suite 1000
hicago, Illinois 60611-1676
Phone: (312) 335-9602
Fax: (312) 335-0214

BIOMEDICAL RESEARCH IN ALZHEIMER'S DISEASE
A selected list of recent publications

General

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Cowley, G. Medical Mystery Tour. Newsweek (December 18, 1989), v.114(25), pp. 59-63.

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Marx, J.L. New clue found to Alzheimer's (research by Bruce Yankner and Neil Kowall). Science (August 23, 1991), v.253(5022), pp. 857-8.

Selkoe, D.J. Amyloid protein and Alzheimer's disease. Scientific American (November 1991), v.265(5), pp. 68-71, 74-76, 78.

Diagnosis

Thomas, P. Alzheimer's disease: is there a test? Harvard Health Letter (January 1991), v.16(3), pp. 1-4.

Morris, J.C. & Rubin, E.H. Clinical diagnosis and course of Alzheimer's disease. Psychiatric Clinics of North America (June 1991), v.14(2), pp. 223-236.

Epidemiology/Risk Factors

Easley, L.P. Is it aluminum? Harvard Health Letter (October 1990), v.15(11), pp. 1-3.

Trèves, T.A. Epidemiology of Alzheimer's disease. Psychiatric Clinics of North America (June 1991), v.14(2), pp. 251-265.

Genetics

Breitner, J.C. Clinical genetics and genetic counseling in Alzheimer disease. Annals of Internal Medicine (October 15, 1991), v.115(8), pp. 601-606.

Li, G., Silverman, J.M. & Mohs, R.C. Clinical genetic studies of Alzheimer's disease. Psychiatric Clinics of North America (June 1991), v.14(2), pp. 267-285.

Causes/etiology (continued)

Gorelick, P.B. & Bózzola, F.G. Alzheimer's disease: clues to the cause. Postgraduate Medicine (March 1991), v.89(4), pp.231-2, 237-8, 240.

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Cooper, J.K. Drug treatment of Alzheimer's disease. Archives of Internal Medicine (February 1991), v.151(2), pp. 245-249.

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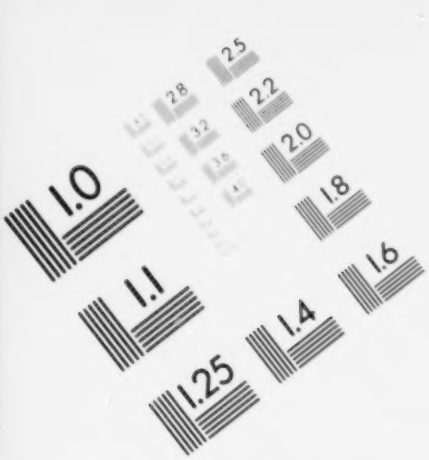
Colenda, C.C. Drug treatment of behavior problems in elderly patients with dementia, Part 2. Drug Therapy (July 1991), v. 21(7) pp.45-51.

Starr, C. Alzheimer's: the stranger among us. Drug Topics (September 3, 1990) v. 134(7), pp. 34-41.

Sevush, S. Psychopharmacology of Alzheimer's disease. Hospital Formulary (November 1990), v. 26 (11), pp. 846-852.

Skelton, W.P. III & Skelton, N.K. Alzheimer's disease: recognizing and treating a frustrating condition. Postgraduate Medicine (September 15, 1991), v.90(4), pp. 33-4, 27-41.

March 20, 1992



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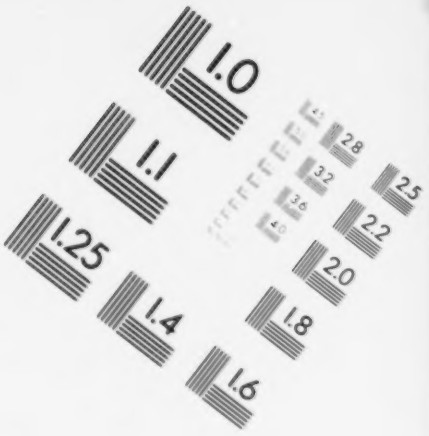

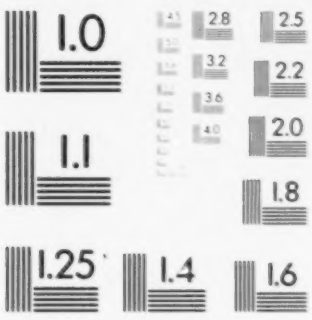

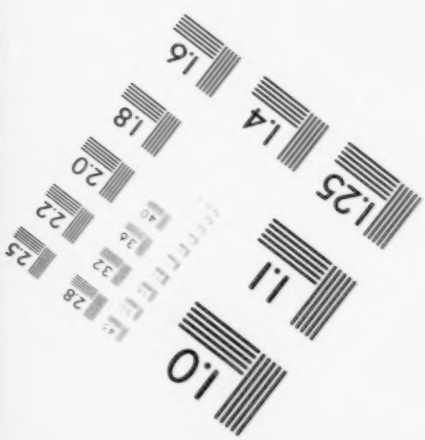

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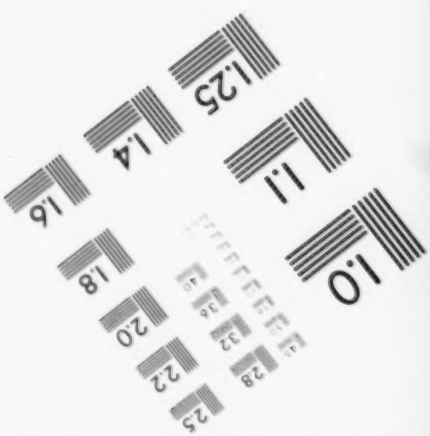

AUDIOVISUAL RESOURCE LIST

Objective I:
A MATTER OF TIME TCGEC
2 hour/video
This video addresses our society's attitudes about aging. It explores people's perspective of old age and the myths of aging. It features interviews with several "older" individuals from various backgrounds.

Objective IV & V:
ASSISTING FAMILIES OF PATIENTS WITH ALZHEIMER'S DISEASE TCGEC
1990/14 min./1/2"
In this video, the social worker interviews a husband and adult daughter of a woman with Alzheimer's Disease. Topics include: assessment of available resources, emotional implications, coping styles, and future planning issues. None of these areas are explored in depth but important suggestions for further exploration are addressed.

Objective IV & X:
FAMILY SUPPORT GROUPS: HELP FOR FAMILIES OF ALZHEIMER'S DISEASE PATIENTS
1990/17 min./1/2"
TCGEC
This video shows a support group in progress with members sharing some of their experiences. It covers the purpose of support groups, common themes, and role of the facilitator.

Objective VII:
THE SIXTH SENSE
TCGEC
27 min./video
Addresses the problems which are created by age-related sensory loss. Reviews the changes which occur in the eye. ear, and nose to cause their loss of function.

Objective X:
ALZHEIMER'S DISEASE: INTERVIEWING AND ASSESSMENT TECHNIQUES FOR SOCIAL WORKERS
TCGEC
20 min./video
Demonsrtates testing techniques and responses from three patients with different degrees of impairment.

Available from: The Texas Consortium of Geriatric Education Centers, at (713) 798-6470.

WHEN THE DAY COMES - WOMEN AS CAREGIVERS (28 minutes)
Distributor: Filmakers Library
124 East 40th Street
New York, N.Y. 10016
(212) 808-4980

HASTA QUE HAY CURA: LA DIAGNOSIS DE LA DEMENCIA (19 minutes)
Distributor: Alzheimer's Disease and Education Referral Center
P.O. Box 8250
Silver Springs, MD 20907-8250
(800) 438-4380

ALLEVIATING STRESS ASSOCIATED WITH NURSING HOME ADMISSION (20 minutes)
Distributor: Video Press
University of Maryland at Baltimore
School of Medicine
100 Penn Street, Suite 133
Baltimore, MD 21201
(800) 328-7450

LIVING LEGACY (30 minutes)
Distributor: The Unicare Foundation, Inc.
105 W. Michigan Street
Milwaukee, WI 53203
(414) 271-9696

AGELESS AMERICAN (52 minutes)
Distributor: Films for the Humanities Service
P.O. Box 2053
Princeton, NJ 08543-2053
(800) 257-5126

NURSE'S AIDES: MAKING A DIFFERENCE (31 minutes)
Distributor: UT Southwestern ADRC Videos
Department of Gerontology and Geriatrics Services
P.O. Box 45567
Dallas, TX 75245

ADDITIONAL AUDIOVISUAL RESOURCES

TEXAS

Audiovisual materials list for Variations in Aging:
Older Minorities curriculum module. 1991

Barbara W.K. Yee, Ph.D.
Dept. of Graduate Studies
School of Allied Health Sciences
University of Texas Medical Branch
Galveston, TX 77550
(409) 772-3038

Gerontological Film Collection at University of North Texas

Center for Studies on Aging Resources
P.O. Box 13438, NT Station
Denton, TX 76203
(817) 565-3457

Health Education Audiovisuals, 1985

Reprographics & Educational Services
Film Library
Texas Department of Health
1100 W. 49th Street.
Austin, TX 78756
(512) 458-7260

GERIATRIC EDUCATION CENTERS (GECs)

A/V Resources for Gerontological & Geriatric Education 1987-88

USC Pacific GEC
1975 Zonal Ave., KAM 300-C
Los Angeles, CA 90033
(213) 224-7994

Bibliography of A/V Resources

Iowa GEC
E 416 General Hospital
University of Iowa Hospitals & Clinics
Iowa City, IA 52242
(319) 356-1027

Catalog of Videotape Resources in Gerontology & Geriatrics

Mississippi GEC
Univ. of Mississippi Medical Center
Alumni House, Room 3321
Jackson, MS 39216-4504
(601) 984-6190

ADDITIONAL NATIONAL RESOURCES

The AARP Audiovisual Library

AARP A/V Programs
Program Scheduling Office
Program Resources Dept.
1909 K Street NW
Washington, D.C. 20049

American Journal of Nursing Multimedia Catalog 1984/88

AJN Company
Educational Services Division/GER
555 West 57th Street
New York, NY 10019
1-800-223-2282

Filmakers Library 1985/86

Filmakers Library, Inc.
133 East 58 Street
New York, NY 10022
(212) 355-6545

Terra Nova Films, Inc.

Terra Nova Films
9848 S. Winchester Avenue
Chicago, IL 60643
(312) 881-8491

Video Press at the University of Maryland at Baltimore

The University of Maryland at Baltimore
School of Medicine
32 South Greene St.
Baltimore, MD 21201
1-800-328-7450
FAX: (410) 328-8471

Catalogue of National Media Award Winners 1985-89

The Retirement Research Foundation
1300 Higgins Road, Suite 214
Park Ridge, IL 60068
(212) 355-6545

SELECTED RESOURCES ON UNDERGRADUATE GERONTOLOGICAL TRAINING

Prepared by Nancy R. Hooyman
University of Washington

Browne, C. and Broderick, A. Aging and ethnicity. University of Hawaii, School of Social Work, 1991.

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Additions from the Project Staff:

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2. Schneider, R. (1989) Undergraduate Social Work Education and Gerontology Series. Council on Social Work Education and Virginia Commomwealth University.

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PRACTICE COMPONENT FOR GERONTOLOGICAL SOCIAL WORK IN UNDERGRADUATE CURRICULA

Underlying issues:

Recognize limitations on the level of knowledge and skills that can be incorporated in undergraduate BSW curriculum

How to identify community resources?

Where to turn when need to know more? (other agencies and professionals, CEE)

Using generalist model of assessment, problem definition, intervention strategies, outcome and follow-up,

What knowledge and skills are generic and which are aging-specific?

What is inherent in the aging process and what results from presence of absence of resources?

Centrality of case management to gerontological social work

Importance of social work's leadership in this area; case management is more than a bureaucratic function of identifying needs and arranging services; involves both B.S.W. and M.S.W. students

Threatened by the emergence of geriatric community health nurses and professionals with degrees in gerontology

Case management functions of assessment, planning, linking, monitoring and advocacy are essential.

Focus on midpoint between clinical models and brokerage models

Social/environmental change along with personal change

Concrete service delivery (finding services, seeking funding options, and monitoring service delivery)

Functions of case management:

Casefinding (outreach, eligibility determination, intake).

Assessment (current status, problem identification; providing concrete service, such as completing Medicare forms during assessment, can be basis for working relationship

Care planning based upon assessment of needs

Arrange for delivery of services through coordination, mediation and resource allocator

Monitor clients/services through follow-up as data collector and documenter

Reassessment and reevaluation

Program change and advocacy to address gaps in service network through consultation, advocacy and development of resources

Assessment protocol for case management should address areas of functioning in a brief, focused way (Gwyther).

- Sociodemographic characteristics

- Functional capacity

Physical capacity

general health functioning

issues related to illness

use of prescription drugs

Psychosocial

Cognitive

Emotional

Individual strengths and preferences

Life cycle adaptation

Present coping to deal with the precipitating event, meaning of event and solution to both the older person and their social networks.

- Environmental context

Sociocultural - use of ethnographic interviewing

Family history

Developmental stages and family's place in the older person's life.

Intergenerational relationships

Family's reaction to older person's needs

Family's reaction to caregiving role

- Utilization of community resources and nature and quality of services (organizational resources context).

Informal support systems

Entitlement programs

Formal support services

Multidisciplinary involvement

Underlying values:

Respect for older people; start with his/her perceptions of own strengths and needs

Commitment to maximum client participation and to a thorough decision-making process

Respect for confidentiality

Right to self-determination, although ethical dilemmas may arise around client self-determination, competency of the client, and the family or community's desire for action

Understand limits of assessment instruments:

Screening devices, not diagnostic tools; becomes baseline for work

Cannot serve as a substitute for a thorough and complete medical and/or psychiatric exam.

Types of interventions:

Involve older person and family members in identifying needs, developing options, choosing among alternatives, and preparing for service acceptance.

Problem-solving, supportive therapy, decision-making and education

Supportive techniques, life review therapy, behavioral approaches, cognitive approaches and socialization.